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Spinal

Healthcare

Associates, PC

CN1212-060

E. GRAHAM BAKER, JR.
ATTORNEY AT LAW IOLTA ACCOUNT
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NASHVILLE, TN 37215

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E. Graham Baker



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CN1212-060



2012 DEC 14 AM 10 29

CERTIFICATE OF NEED APPLICATION

for the

**Development and Establishment of a Specialty ASTC,
Performing MUA, Only**

by

**Spinal Health Care Associates, P.C.
8132 Cordova Road, Suite 101
Cordova, TN 38106**

**STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
ANDREW JACKSON BUILDING
500 DEADERICK STREET, SUITE 850
NASHVILLE, TENNESSEE 37243**

Filing Date: December 14, 2012

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency or Institution

Spinal Health Care Associates, P.C.

Name

8132 Cordova Road, Suite 101

Street or Route

Shelby

County

Cordova,

City

TN

State

38106

Zip Code

2. Contact Person Available for Responses to Questions

E. Graham Baker, Jr.

Name

Attorney

Title

Weeks and Anderson

Company Name

graham@grahambaker.net

e-mail address

2021 Richard Jones Road, Suite 350

Street or Route

Nashville,

City

TN

State

37215

Zip Code

Attorney

Association with Owner

615/370-3380

Phone Number

615/221-0080

Fax Number

3. Owner of the Facility, Agency, or Institution

Rock Wooster, D.C.

Name

901-751-0939

Phone Number

8132 Cordova Road, Suite 102

Street or Route

Shelby

County

Cordova,

City

TN

State

38106

Zip Code

4. Type of Ownership of Control (Check One)

A. Sole Proprietorship

B. Partnership

C. Limited Partnership

D. Corporation (For-Profit)

E. Corporation (Not-for-Profit)

F. Governmental (State of Tenn.
or Political Subdivision)

G. Joint Venture

H. Limited Liability Company

I. Other (Specify)

Professional For-Profit Corp

 x

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. See Attachment A.4.

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses' on this form. All questions must be answered. If an item does not apply, please indicate "N/A". *Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.*

Section A, Item 1: Facility Name must be applicant facility's name and address must be the site of the proposed project.

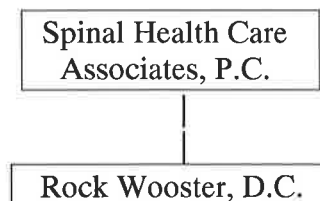
Response: Spinal Health Care Associates, P.C. is the Applicant. See Response to A.1. The Applicant will be located at 8132 Cordova Road, Suite 101, Cordova, Shelby County, TN 38106, which is the site of the proposed project. The Owner, Rock Wooster, D.C., is located in an adjoining suite (Suite 102) at the same address.

Section A, Item 3: Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

Response: See Attachment A.4.

Section A, Item 4: Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, §68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

Response: The Applicant is a professional corporation, owned by Rock Wooster, D.C., and is self-managed. The organizational chart is below:



The Applicant does not own any other health care institution in Tennessee, as defined in TCA §68-11-1602.

Section A, Item 5: For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

Response: Not applicable, as there is no management entity.

Section A, Item 6: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.

Response: The Applicant will lease space from Rock A. Wooster and Jason Coleman, the landlord.

Please see *Attachment A.6*.

As the fair market value (FMV) of the total land and building is \$1,720,000, and the percentage of leased space is approximately 16.7% (actually, 1/6th of the total space), the Project Costs Chart, under Section B.1., lists the FMV of the facility as \$286,667. The FMV is higher than the lease cost (\$144,000), so the FMV is listed on the chart.

5. Name of Management/Operating Entity (If Applicable)

Not applicable

Name

Street or Route

County

City

State

Zip Code

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. Not applicable.

6. Legal Interest in the Site of the Institution (Check One)

- | | | | |
|----------------------------|----------|--------------------|-------|
| A. Ownership | _____ | D. Option to Lease | _____ |
| B. Option to Purchase | _____ | E. Other (Specify) | _____ |
| C. Lease of <u>3</u> Years | <u>X</u> | | _____ |

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. See Attachment A.6.

7. Type of Institution (Check as appropriate--more than one response may apply.)

- | | | | |
|--|----------|--|----------|
| A. Hospital | _____ | I. Nursing Home | _____ |
| B. Ambulatory Surgical Treatment Center (Multi-Specialty) | _____ | J. Outpatient Diagnostic Center | _____ |
| C. ASTC | <u>X</u> | K. Recuperation Center | _____ |
| D. Home Health Agency | _____ | L. Rehabilitation Facility | _____ |
| E. Hospice | _____ | M. Residential Hospice | _____ |
| F. Mental Health Hospital | _____ | N. Non-Residential Methadone Facility | _____ |
| G. Mental Health Residential Treatment Facility | _____ | O. Birthing Center | _____ |
| H. Mental Retardation Institutional Habilitation Facility (ICF/MR) | _____ | P. Other Outpatient Facility (Specify) _____ | _____ |
| | | Q. Other (Specify) <u>specialty ASTC</u> | <u>X</u> |

8. Purpose of Review (Check as appropriate--more than one response may apply.)

- | | | | |
|--|----------|---|-------|
| A. New Institution | <u>X</u> | H. Change In Bed Complement (Please note the type of change by underlining the appropriate response: Increase, Decrease Designation, Distribution Conversion, Relocation) | _____ |
| B. Replacement/Existing Facility | _____ | I. Change of Location | _____ |
| C. Modification/Existing Facility | _____ | J. Other (Specify) _____ | _____ |
| D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) | _____ | | _____ |
| E. Specify _____ | _____ | | _____ |
| F. Discontinuance of OB Services | _____ | | _____ |
| G. Acquisition of Equipment | _____ | | _____ |

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

Response: Not applicable, as no beds are involved in this application.

	Current Beds		Staffed	Beds	TOTAL
	<u>Licensed</u>	<u>CON*</u>	<u>Beds</u>	<u>Proposed</u>	<u>Beds at Completion</u>
A. Medical	_____	_____	_____	_____	_____
B. Surgical	_____	_____	_____	_____	_____
C. Long-Term Care Hospital	_____	_____	_____	_____	_____
D. Obstetrical	_____	_____	_____	_____	_____
E. ICU/CCU	_____	_____	_____	_____	_____
F. Neonatal	_____	_____	_____	_____	_____
G. Pediatric	_____	_____	_____	_____	_____
H. Adult Psychiatric	_____	_____	_____	_____	_____
I. Geriatric Psychiatric	_____	_____	_____	_____	_____
J. Child/Adolescent Psychiatric	_____	_____	_____	_____	_____
K. Rehabilitation	_____	_____	_____	_____	_____
L. Nursing Facility (non-Medicaid Certified)	_____	_____	_____	_____	_____
M. Nursing Facility Level 1 (Medicaid only)	_____	_____	_____	_____	_____
N. Nursing Facility Level 2 (Medicare only)	_____	_____	_____	_____	_____
O. Nursing Facility Level 2 (dually-certified)	_____	_____	_____	_____	_____
P. ICF/MR	_____	_____	_____	_____	_____
Q. Adult Chemical Dependency	_____	_____	_____	_____	_____
R. Child & Adolescent Chemical Dependency	_____	_____	_____	_____	_____
S. Swing Beds	_____	_____	_____	_____	_____
T. Mental Health Residential Treatment	_____	_____	_____	_____	_____
U. Residential Hospice	_____	_____	_____	_____	_____
 TOTAL	_____	_____	_____	_____	_____

*CON Beds approved but not yet in service

10. Medicare Provider Number will be applied for
Certification Type Specialty ASTC
11. Medicaid Provider Number will be applied for
Certification Type Specialty ASTC

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid?

Response: This is a new facility, and certification will be sought for Medicare and Medicaid. Manipulation under Anesthesia (“MUA”¹) is a relatively new service in Tennessee, currently approved only in Knoxville and Nashville. The Applicant believes that both Medicare and Medicaid have payment mechanisms available for MUA patients. However, whether or not these programs recognize MUA as a reimbursable service, the Applicant will still take patients who qualify for these programs. If these programs do not reimburse for MUA, the Applicant will write off the cost as charity care. Further, the Applicant will take Medicaid (TennCare) patients out of contract if standard provider contracts are not available.

MEDICARE: Certification will be sought for Medicare. While Medicare has a reimbursement mechanism for MUA, the majority of Medicare patients may have medical conditions that are contraindicated for MUA. In effect, most aged patients have systemic problems that preclude them from being candidates for MUA procedures. Therefore, the Applicant believes that Medicare patients will be such a small percentage of patients (15%). If reimbursement is available, such application will be sought. If reimbursement is not available, the procedures will be written off as charity care. The main factor in taking such patients will be whether or not each patient is a candidate for MUA based on his/her respective medical condition.

TENNCARE: Certification will be sought for TennCare. The Applicant understands that Medicaid reimburses for MUA procedures, and believes that TennCare will, also. The Applicant will take any TennCare patients out of network. If reimbursement is not available, the procedures will be written off as charity care. Again, the main factor in taking such patients will be whether or not each patient is a candidate for MUA based on his/her respective medical condition.

While there are CPT codes for various MUA procedures, we are not sure if reimbursement will be available for such patients until such time as we actually provide the procedures and submit the claims for payment. In the meantime, we plan to provide MUA services to Medicare and TennCare patients in any regard, and if reimbursement is not available, we will simply declare such services as charity care. We are aware of several insurance companies that reimburse for MUA care, but reimburse at discounted rates.

MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it can not be and is not recognized by legal definition as an experimental or investigational procedure. Insurance carriers that are designating MUA of any area as experimental or investigational have the burden of proof to defend their position that this procedure is experimental. To date, such attempts have been unsuccessful in a court of law. Therefore, since MUA

¹ “MUA” stands for Manipulation under Anesthesia, defined in the application. MUA also includes “MUJA” which is Manipulation under Joint Anesthesia, which involves injecting anti-inflammatory medication into painful inflamed joints in connection with MUA procedures. When used in this application, the term “MUA” will also include “MUJA.”

is considered a category 1 procedure by CPT, it is neither an experimental nor investigational procedure.

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Will this project involve the treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract. Discuss any out-of-network relationships in place with MCOs/BHOs in the area.***

Response: The only current TennCare MCOs in the West Tennessee area appear to be UHC/AmeriChoice, Blue Care and TNCare Select. The Applicant will seek contracts with these and all other MCOs who provide services in our geographic area.

The Applicant, through its Owner, has existing relationships as indicated below, and plans to continue those relationships:

Humana Gold;
Windsor; and
United Health Care Secured Plus.

NOTE: *Section B is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. Section C addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.*

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response: Spinal Health Care Associates, P.C. ("Applicant"), 8132 Cordova Road, Suite 101, Cordova, TN 38106, owned by Rock Wooster, D.C., 8132 Cordova Road, Suite 102, Cordova, TN 38106, and managed by itself, files this application for a Certificate of Need for establishment of a specialty ambulatory surgical treatment center ("ASTC") providing only manipulation under anesthesia ("MUA") services. This new ASTC will be located in an existing office building, and will have one (1) procedure room, one (1) exam room, one (1) recovery room, along with other related space. The Applicant will provide only MUA and related services, which are manual surgical procedures, and no operative surgical procedures will be performed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately \$471,667, which includes the cost of the filing fee.

The Applicant is owned by Rock Wooster, D.C., and is self-managed. Articles of Organization and the organizational chart are attached as *Attachment A.4*. The only member of the Applicant is Dr. Wooster.

MUA is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the 1930s. Leading references put the use of MUA in the United States as far back as 1938, when Persols International Medical Clinic from Great Britain brought the procedures to the United States through Doctors Shiel, Clauborne, Mensor, and others, as reported in the Bibliography in the textbook, "Manipulation Under Anesthesia, Concepts In Theory and Application," Gordon, R., et.l., Taylor and Francis, April 2005. The process involves relaxing the patient (with anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

MUA also includes MUJA, which stands for Manipulation Under Joint Anesthesia, and involves injecting anti-inflammatory medication into painful inflamed joints both in conjunction with the biomechanical alterations accomplished with the MUA techniques, and as a screening tool. Patients suffering more severe or complex joint pain have a better response to the MUA techniques when afforded this medication. However, if such a joint injection completely alleviates the pain, such blocks may well preclude the need for additional MUA procedures for some patients. In effect, MUJA procedures are part of the MUA continuum of care.

MUA procedures must be performed in a designated area where anesthesia is provided. To do that, a facility must meet the basic needs of a proper room, life support, room for the movement of the physicians involved in the procedure, as well as room for the nursing staff and the anesthesiologist. The designation of a “clean room” can be used in this case since this procedure does not require a sterile environment. The Applicant believes that such procedures should be administered in a licensed, regulated environment by licensed, regulated physicians to ensure proper protocols are followed, thereby ensuring that the procedures are performed correctly, keeping in mind the patients’ health.

While MUA procedures could have been conducted in a physician’s office in the past, such is not desirable for the reasons stated above. There is no current licensure designation for a clinic in which to perform MUA procedures, only. However, according to the Board for Licensing Health Care Facilities, Department of Health, such procedures could be performed in a “specialized” ASTC. Therefore, the Applicant is applying for a specialized ASTC, limiting the procedures to be performed to MUA, only.

A decision by the Board of Chiropractic Examiners would have the effect of limiting MUA procedures to certified facilities, so “in-office” procedures are a thing of the past. On February 21, 2008, the Board of Chiropractic Examiners adopted the following position statement:

“A licensed Tennessee chiropractor may provide chiropractic services to a patient who is under anesthesia if and only if:

- (1) The chiropractic physician has received certification from an institution accredited by the Council on Chiropractic Education (CCE) and pursuant to a course of study recognized by the National Manipulation Under anesthesia (MUA) Academy of Physicians and/or the International MUA Academy of Physicians; and
- (2) The anesthesia is administered in a facility properly equipped and certified as required by law to administer anesthesia; and
- (3) The anesthesia is administered by – and the anesthetized patient is at all times monitored by – an anesthesiologist or other healthcare professional who is legally qualified to perform and monitor anesthesia.”

This Applicant will comply with this position statement.

MUA is within the scope of practice of DCs, MDs and DOs in all states. The Applicant (through its consultant) is aware of MUA being performed in licensed facilities in New Jersey, New York, Missouri, Kentucky, Texas, Montana, California, Utah, Florida, Oklahoma, Kansas, Louisiana, South Carolina, Arizona, and, now, Tennessee.

According to Dr. Robert C. Gordon, a nationally-recognized leader in the provision of MUA (See *Attachment B.II.A* for a curriculum vitae’), the risks over the past 20 years of performing this technique have been very minimal. Most of the occurrences have been limited to patient reaction to anesthesia, not following proper anesthesia protocols (being NPO 6-8 hours before the procedure), and to the selection of patients who are inappropriate candidates for MUA. This is the reason for the Applicant’s insistence on rigorous training required by the physicians performing the procedure, including testing and proctoring before receiving a certificate of training. This is also the reason that the specific training that has been sited in this application is more accountable than other training programs that may be out there. (Also, please see *Attachment B.II.A.1* for copies of three case studies on MUA).

Physicians have expressed concern about the treatment of chronic pain. Chronic pain has both chemical and mechanical components. Such treatment is difficult, sometimes ineffective, and has risks. These risks include narcotic abuse, misuse and diversion, and infection (such as when utilizing Epidural Steroid Injections). There appears to be general consensus that a procedure that could significantly lower pain scores, improve functional capacity, and reduce narcotic use would be invaluable in the treatment of chronic pain. MUA is such a procedure.

X-rays are performed on every patient by the referring chiropractor, and will occur well in advance of the patient being referred to the facility. In some cases, MRI procedures will also be performed. Such diagnostic tests have to be performed in order to determine whether or not the patient is a candidate for MUA procedures. However, such diagnostic exams are not part of this project.

According to Dr. Gordon, Doctors of Chiropractic average seeing approximately 110 patients per week, and about 5% of those patients are candidates for MUA due to chronic pain. Once MUA procedures are administered, only about 0.5% of all MUA cases are considered repeatable. This is due to properly selecting the right cases for the procedure based on the NAMUAP standards and Protocols. Following the 3-day procedure, patients are shown physical therapy exercises and stretching methods in order to maintain optimal health.

The average age range for traditional MUA patients is approximately 25-62, but is not specifically limited to this age group. A brief explanation of the process to be followed is as follows:

1. Patients will need three procedures on three successive days (they will be transported to/from the facility, negating the need for overnight stays at the ASTC);
2. Patients will enter through the Reception area;
3. The patient is taken to a room to complete paperwork and receive final instructions on the procedure;
4. The actual procedure is performed in the Procedure Room;
5. The patient will then go to the Recovery Room;
6. Each patient will then receive post-therapeutic treatment;
7. And then be taken from the facility.

It is also important to note that only one patient will be under anesthesia at a time, and that patient will be attended to by at least one chiropractic doctor and at least one (either) medical doctor or doctor of osteopathy during the entire time the patient is unconscious. Anesthesia will be administered by either an Anesthesiologist or a CRNA working for an Anesthesiologist. Further, an RN will also attend the patient at all times.

Patients must have medical clearance for anesthesia. Also, patients have to have had testing for the procedure (standard testing is CBS/Diff and sometimes an SMA6). If the patient is over 50 years of age, he/she will need an EKG; if the patient has a history of respiratory difficulty, a Chest X-Ray will be required. Finally, a pregnancy test will be given to female patients.

Both the person administering anesthesia and the recovery room nurse must be ACLS certified in life support. Following the MUA procedure, each patient will go to the Recovery Room for gentle stretching and physical therapy, including Interferential (electrical stimulation) therapy, and then ice. Following this, the patient will have a massage prior to discharge. The time for such post-therapeutic care must be designated only by the condition of each patient. It is not a probable assumption to conclude that all persons receiving post MUA therapy would receive the exact same amount of therapy,

since the conditions that they have would vary from one patient to another. Following the procedure, most patients are fully capable of ambulation. However, it is advised that someone (either our staff, a family member, or friend) drive the patient to their destination in order for the patient to receive rest and relaxation.

The Applicant will lease the physical space and own the equipment. As limited staff are needed, the Applicant anticipates no problem in securing appropriate staff for the operation of the ASTC.

Since MUA is a relatively new procedure to be regulated in Tennessee, there are no comparable facilities in Tennessee with which to compare utilization, or to gather any other forms of comparable data. While two facilities are already approved (in Nashville and Knoxville), utilization data (such as would be contained in JARs) is not available. Since MUA procedures have been performed since the 1930s, it is assumed that they were being performed, albeit to a limited extent, in Tennessee. However, there exists no data for such procedures if they were performed, at all.

Proposed staff include an administrator, a coordinating clerk, and RN. Administrative staff is already available on staff of the Owner. The RN will be paid approximately \$47,000 annual salary. The anesthesiologist and/or CRNA will bill for services separately, as will the physicians. The Applicant plans on working with area training programs to allow students to rotate through our facility to complete clinical training requirements. Further, doctors will be trained in the clinic.

The Applicant anticipates an average gross charge per patient in Year 1 of operation of \$15,000, with an average deduction of approximately \$9,191, for an average net charge of approximately \$5,808 per patient. Projections indicate positive cash flow the first two years of operation (see Projected Data Chart).

It is projected that 130 and 170 MUA procedures will be performed in years 1 and 2, respectively. These projections are based on statistical projections of chiropractic practices, coupled with anecdotal information retrieved from several doctors in the area.

The Applicant projects that approximately 15% of the total patients will be Medicare, and approximately 80% will be Medicaid/TennCare. The remaining 5% are expected to be Commercial Insurance patients. The Applicant does anticipate contractual adjustments from insurance companies, and has allowed for that in the Projected Data Chart.

Unfortunately, there still remain a few insurance companies that consider MUA an experimental or investigative procedure. Some providers have surmised that an insurance company receives monthly premiums from policy holders and is supposed to pay for covered procedures if and when the policy holders submit claims. The more claims that are paid, the less profit for the insurance company. If the insurance company does not want to pay the claim, there are several responses to such claims which either decrease the possibility of paying the claim, or at least, delay the payment. These responses include, but are not limited to, "You aren't covered; this procedure isn't covered; this procedure is experimental; the paperwork for the claim isn't completed properly; the claimant had a pre-existing condition which was not divulged on the application form; we have no record of your claim;" etc. Any delay is a delay.

However, it is a fact that MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it can not be and is not recognized by legal definition as an experimental or investigational procedure. Insurance carriers that are designating MUA of any area as experimental or investigational have the burden of proof to defend their position that this

procedure is experimental. To date, such attempts have been unsuccessful in a court of law. Therefore, since MUA is considered a Category 1 procedure by CPT, it is neither an experimental nor an investigational procedure.

The Applicant has every intention of working with both the HSDA and the Tennessee Department of Health, Division of Licensing Health Care Facilities, to coordinate useful licensing requirements and utilization standards for facilities such as is proposed in this application. In fact, a representative of the Applicant has already met with representatives of the Board for Licensing Health Care Facilities in this regard. Please see *Attachment C.N.5* for a copy of working protocols for MUA procedures. Note that all physicians who perform these procedures at our clinic must have achieved at least 36 hours of postgraduate instruction in MUA from a CCE/CME accredited Chiropractic or Medical School. This training covers an array of instruction areas, including but not limited to, the history of MUA procedures, the scientific basis of the MUA procedure, the clinical application of the patients for MUA, the proper selection of patients for MUA, clinical (hands-on) training, and both oral and written examinations. Robert C. Gordon, D.C., the previously-mentioned consultant, is already training doctors in Tennessee for MUA procedures and has trained doctors in other states for years. In fact, he has trained all of the doctors affiliated with this project.

According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. It should be assumed that existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. Please see *Attachment C.OD.3* for a list of sample wage information for the service area.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of \$5 million) and other facility projects (construction cost in excess of \$2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

Response: The Applicant's Owner has a chiropractic practice at the same address, but adjacent to the space to be renovated for this project. Approximately 2,100 GSF will be renovated in Suite 101 at a total cost of \$110,000 (\$10,000 site preparation plus \$100,000 renovation costs). Please see *Attachment B.II.A.2* for a letter stating that this amount (\$110,000) is sufficient for renovation costs.

The Applicant will purchase a used C-Arm, which will be utilized to properly place any injection needles associated with MUJA. This piece of equipment will cost \$40,000.

Finally, the total land and building have a combined fair market value (FMV) of \$1,720,000. The space for this ASTC will approximate 1/6th of the building. Therefore, the FMV of the real estate for this project is approximately \$286,667. As the rent (initial term of the lease is 3 years) will be \$4,000 per month, the FMV exceeds the actual lease costs (\$144,000). The FMV is listed on the Project Costs Chart.

- B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.**

Response: Not applicable, as no beds are involved in this project.

- C. As the applicant, describe your need to provide the following health care services (if applicable to this application):**

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

Response: Not applicable.

D. Describe the need to change location or replace an existing facility.

Response: Not applicable.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of \$1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

a. Describe the new equipment, including:

- 1. Total cost; (As defined by Agency Rule)**
- 2. Expected useful life;**
- 3. List of clinical applications to be provided; and**
- 4. Documentation of FDA approval.**

b. Provide current and proposed schedules of operations.

Response: Not applicable.

2. For mobile major medical equipment:

- a. List all sites that will be served;**
- b. Provide current and/or proposed schedule of operations;**
- c. Provide the lease or contract cost.**
- d. Provide the fair market value of the equipment; and**
- e. List the owner for the equipment.**

Response: Not applicable.

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response: Not applicable.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

- 1. Size of site (*in acres*)**
- 2. Location of structure on the site; and**
- 3. Location of the proposed construction.**
- 4. Names of streets, roads or highway that cross or border the site.**

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

Response:

1. The site on which the medical building is located is approximately 1.574 Acres.
2. See *Attachment B.III.*
3. There is no construction, *per se*. Existing space will be renovated and utilized. The Applicant has budgeted \$110,000 for renovation costs (see Project Costs Chart), which includes \$10,000 for site preparation plus \$100,000 for renovation. The location of the ASTC is noted on Attachment B.III.3 ("ASTC").
4. The ASTC will be located at the corner of Country Village Drive and Cordova Road, which is very close to Germantown Parkway. The Agricultural Center of Memphis is located just down the street. The site is very close to I-40, which transects the city.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: Public transportation is available, and the site is readily accessible for patients.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.

Response: Please see *Attachment B.IV*, which contains a footprint of the proposed ASTC.

V. For a Home Health Agency or Hospice, identify:

- 1. Existing service area by County;**
- 2. Proposed service area by County;**
- 3. A parent or primary service provider;**
- 4. Existing branches; and**
- 5. Proposed branches.**

Response: Not applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), “no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care.” The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate “Not Applicable (NA).”

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee’s Health: Guidelines for Growth.
 - a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Response: Please see *Attachment Specific Criteria*.

Also, State Health Plan criteria is as follows:

1. **The purpose of the State Health Plan is to improve the health of Tennesseans;**

The Applicant’s Owner has been serving patients for many years, and continues to this day. Services are provided to a select group of patients who have special chiropractic needs. The approval of this project will help continue those needed services.

2. **Every citizen should have reasonable access to health care;**

The Applicant will accept all patients who present for care, irrespective of their ability to pay.

3. **The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system;**

The development of this service by the Applicant is the result of an attempt to meet the needs of Tennesseans. The service to be offered by this project does not exist in the service area.

4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers; and

Tennessee is fortunate to have an excellent licensing division of the Department of Health. The Board of Licensing Health Care Facilities provides standards for and monitoring of licensed health care providers. This Applicant will be fully licensed by the Department of Health and will request certification by both Medicare and Medicaid (TennCare).

5. The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.

The Applicant is committed to providing safe working conditions for its staff and continuing education to its staff.

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).

Response: Not applicable.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response: There is no long-range development plan of the Applicant, other than to provide a facility in which MUA procedures will be performed. MUA has been utilized for decades to alleviate pain and increase the range of motion for patients. This particular project is to be located in Memphis, but the actual referring area is anticipated to extend beyond the county of situs to outlying areas. The service area consists of Shelby, Fayette and Tipton Counties, which counties reflect patient origin for the majority of patients seen by the Applicant's Owner. If utilization and need for this service eventually extends to other areas of the state, the Owner of the Applicant may well pursue MUA facilities in those areas. Common sense dictates that areas of higher population concentration would be targeted first.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).

Response: The Applicant's service area consists of Shelby, Fayette and Tipton Counties, which counties reflect patient origin for the majority of patients seen by the Applicant's Owner.

See *Attachment C.N.3* for a map of the proposed service area.

4. A. Describe the demographics of the population to be served by this proposal.

Response: The primary area to be served (Fayette, Shelby and Tipton County residents) is an urban community with rural and industrial influences. Memphis (Shelby County) is the hub of a Standard Metropolitan Statistical Area (SMSA). Please see *Attachment C.N.4.A* for a listing of Quick Facts about the three counties in our service area.

The following chart lists 2013, 2015 and 2017 population estimates for the service area:

Population Estimates for Service Area

County	Estimated 2013 Population	Estimated 2015 Population	Estimated 2017 Population
Fayette	39,818	41,105	41,841
Shelby	956,126	970,591	983,298
Tipton	63,857	65,839	67,365
TOTAL	1,059,801	1,077,535	1,122,504

Source: Population Estimates and Projections, Tennessee Counties and the State, 2010 – 2020, Office of Health Statistics, Bureau of Health Informatics, Tennessee Department of Health.

- B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.**

Response: The Applicant believes that a special need exists resulting from overmedicating of patients with painkillers. Indications are that Tennesseans may be receiving too many prescription pain medications.

According to a column² in the *Nashville Tennessean* of September 12, 2010,

“Tennessee recently earned the dubious distinction of being named the nation’s second-most medicated state, just behind West Virginia. Abuse of prescription pain medications is occurring at far greater rates today than at any time in the past 10 years.”

The same article goes on to state:

“We recognize how important it is for people to have access to life-saving medications. Taking prescription drugs under a doctor’s supervision is not a bad thing – they can help improve the quality of life for those suffering from debilitating illnesses, and strides have been made in the United States to improve patient access to pain medications.

“However, as important as it is for people to have access to prescription drugs for legitimate purposes, it is equally important to reduce prescription drug abuse and diversion.”

Another column³ on the same page states:

“Surprisingly, the most common addiction that I see people confronting these days is not alcohol, marijuana, cocaine or methamphetamine – but prescription painkillers.

“America leads the world in prescription medication use, and Tennessee is the second-most-heavily medicated state. Our love affair with various sedative narcotics, which are taken as pain relievers, is a serious problem that must be addressed. We must learn to deal with pain in different ways.”

That article concludes with:

“If we each take steps to incorporate alternative pain relief therapies into our lives, we can collectively help combat the rising epidemic of prescription paid medication addition.”

MUA is a proven alternative pain relief therapy, and should be available for Middle Tennessee residents.

² The *Tennessean*, Sunday, September 12, 2010, Page 21A, “Need to curb abuse is critical” by Gil Kerlikowske, Director of the Office of National Drug Control Policy.

³ The *Tennessean*, Sunday, September 12, 2010, Page 21A, “How we view pain makes difference” by Sheila Nickell, a provider of intervention services for addiction disorders at Centerstone of Nashville, TN.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: There are no similar existing or certified services in the service area. The first MUA ASTC to be licensed in Tennessee is in Knoxville, and the second (and last) MUA ASTC to be licensed is in Nashville. Neither of these facilities have reported JAR information yet, as they have only recently been licensed.

The Applicant has every intention of working with both the HSDA and the Tennessee Department of Health, Division of Licensing Health Care Facilities, to coordinate useful licensing requirements and utilization standards for facilities such as is proposed in this application. In fact, a representative of the Applicant has already met with representatives of the Board for Licensing Health Care Facilities in this regard. Please see *Attachment C.N.5* for a copy of working protocols for MUA procedures. Note that all physicians who perform these procedures at our clinic must have achieved at least 36 hours of postgraduate instruction in MUA from a CCE/CME accredited Chiropractic or Medical School. This training covers an array of instruction areas, including but not limited to, the history of MUA procedures, the scientific basis of the MUA procedure, the clinical application of the patients for MUA, the proper selection of patients for MUA, clinical (hands-on) training, and both oral and written examinations. Robert C. Gordon, D.C., the previously-mentioned consultant, is already training doctors in Tennessee for MUA procedures and has trained doctors in other states for years. In fact, he has trained all of the doctors affiliated with this project.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: There is no historical utilization as this application is for a new facility.

The Applicant anticipates an average gross charge per patient in Year 1 of operation of \$15,000, with an average deduction of approximately \$9,191, for an average net charge of approximately \$5,809 per patient.

Clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy, and anesthesiologists, will bill for their own respective services. The Applicant has no control over the billing or participating insurance providers for these clinical professionals.

Procedures: It is projected that 130 and 170 MUA procedures will be performed in years 1 and 2, respectively. These projections are based on statistical projections of chiropractic practices, coupled with anecdotal information retrieved from several doctors in the area.

Medicare and TennCare Revenue Projections: The Applicant projects that approximately 15% of the total patients will be Medicare, and approximately 80% will be Medicaid/TennCare. The remaining 5% are expected to be Commercial Insurance patients. The Applicant does anticipate contractual adjustments from insurance companies, and has allowed for that in the Projected Data Chart.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.
- All projects should have a project cost of at least \$3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
- The cost of any lease should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater.
- The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
- For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.

Response: The Project Costs Chart is completed. This Application includes the fair market value (FMV) of the space at the new specialty ASTC location (actual lease amount is approximately \$144,000 for 3 years, which is lower than the FMV of \$286,667), equipment costs, and legal and administrative fees. The 2,100 GSF facility will be renovated for a total cost of \$110,000, which amounts to approximately \$52.39 per GSF. Considering these conservative projections, the relatively low cost of this project is very reasonable when compared to recent ASTC CON applications.

Please see *Attachment B.II.A.2* for a letter from the contractor.

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase.			2012 DEC 14 AM 10 30	
1.	Architectural and Engineering Fees		\$	3,000 00
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant			30,000 00
3.	Acquisition of Site			
4.	Preparation of Site			10,000 00
5.	Construction Costs (Possible Renovation)			100,000 00
6.	Contingency Fund			
7.	Fixed Equipment (Not included in Construction Contract)			
8.	Moveable Equipment (List all equipment over \$50,000) (NONE OVER \$50K)			40,000 00
9.	Other (Specify)			
		Subsection A Total		183,000 00
B. Acquisition by gift, donation, or lease.				
1.	Facility (Inclusive of Building and Land) (Estimated FMV)			286,667 00
2.	Building Only			
3.	Land Only			
4.	Equipment (Specify)			
5.	Other (Specify)			
		Subsection B Total		286,667 00
C. Financing costs and fees				
1.	Interim Financing			
2.	Underwriting Costs			
3.	Reserve for One Year's Debt Service			
4.	Other (Specify)			
		Subsection C Total		0 00
D.	Estimated Project Cost (A + B + C)		\$	469,667.00
E.	CON Filing Fee		\$	3,000.00
F.	Total Estimated Project Cost (D + E)	TOTAL	\$	471,667.00

* estimated FMV will be paid by (lower) rental costs over time and are considered operational costs; therefore, the only "new" money required for the project is less than total listed above.

2. Identify the funding sources for this project.

- a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (*Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.*)**

- ☐ **A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**
- ☐ **B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**
- ☐ **C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**
- ☐ **D. Grants--Notification of intent form for grant application or notice of grant award; or**
- ☒ **E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**
- ☐ **F. Other—Identify and document funding from all other sources.**

Response: The Applicant's Owner will fund this project with cash reserves. *Attachment C.EF.2* is a letter from the Owner's bank, indicating that sufficient resources are available in existing accounts.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

Response: The Project Costs Chart is completed. This Application includes the fair market value (FMV) of the space at the new specialty ASTC location (actual lease amount is approximately \$144,000 for 3 years, which is lower than the FMV of \$286,667), equipment costs, and legal and administrative fees. The 2,100 GSF facility will be renovated for a total cost of \$110,000, which amounts to approximately \$52.39 per GSF. Considering these conservative projections, the relatively low cost of this project is very reasonable when compared to recent ASTC CON applications.

Please see *Attachment B.II.A.2* for a letter from the contractor.

The Applicant will bill for facility charges, only. The initial gross fee is based on standard fees for MUA facilities in Florida and Tennessee. Operating expenses for the facility include rent, staffing, supplies, medical director, and other expenses as noted on the Projected Data Chart.

Clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy, and anesthesiologists, will bill for their own respective services. The Applicant has no control over the billing or participating insurance providers for these clinical professionals.

No post-outpatient MUA services is required.

The patients will be charged one fee, but this one fee is for a three-day process. The procedure is completed in 3 days in a row as a way of controlling arthrokinetic dyskinesia which has caused fibroblastic proliferative changes. (Please refer to Chapter 2 of Gordon, R. "Manipulation Under Anesthesia, Concepts In Theory and Application"). Since the reference states that adhesions (fibroblastic proliferative changes) will reform in 24-48 hours if left unattended (Guyton, Alter, Koltke), serial MUA performed successively in a three-day format, completed independently on each of the successive days, is how this procedure releases the adhesion proliferation, and continues to resolve the patients aberrant biomechanical pathology.

4. **Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the Proposal Only (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).**

Response: Historical and Projected Data Charts are completed.

Historical Data Chart:

The Historical Data Chart has no figures, as this application is for a new facility.

Projected Data Chart:

This chart includes projected data for the Applicant. Note that the Applicant anticipates positive cash flow in both years.

Procedures: It is projected that 130 and 170 MUA procedures will be performed in years 1 and 2, respectively. These projections are based on statistical projections of chiropractic practices, coupled with anecdotal information retrieved from several doctors in the area.

Medicare and TennCare Revenue Projections: The Applicant projects that approximately 15% of the total patients will be Medicare, and approximately 80% will be Medicaid/TennCare. The remaining 5% are expected to be Commercial Insurance patients. The Applicant does anticipate contractual adjustments from insurance companies, and has allowed for that in the Projected Data Chart.

FMV and Lease Costs: As stated, the fair market value of the total building and land is \$1,720,000, and the percentage of leased space for this project results in a FMV of the leased space of approximately \$286,667. The actual lease cost is \$144,000. Per instructions, the higher FMV is used on the Project Costs Chart.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency.
The fiscal year begins in January (month).

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Response:

	<u>Yr-1</u>	<u>Y-2</u>	<u>Yr-3</u>
A. Utilization/Occupancy Rate (visits)	<u>0</u>	<u>0</u>	<u>0</u>
B. Revenue from Services to Patients			
1. Inpatient Services	<u>0</u>	<u>0</u>	<u>0</u>
2. Outpatient Services	<u>0</u>	<u>0</u>	<u>0</u>
3. Emergency Services	<u>0</u>	<u>0</u>	<u>0</u>
4. Other Operating Revenue (Specify) _____	<u>0</u>	<u>0</u>	<u>0</u>
Gross Operating Revenue	<u>0</u>	<u>0</u>	<u>0</u>
C. Deductions from Operating Revenue			
1. Contractual Adjustments	<u>0</u>	<u>0</u>	<u>0</u>
2. Provision for Charity Care	<u>0</u>	<u>0</u>	<u>0</u>
3. Provision for Bad Debt	<u>0</u>	<u>0</u>	<u>0</u>
Total Deductions	<u>0</u>	<u>0</u>	<u>0</u>
NET OPERATING REVENUE	<u>0</u>	<u>0</u>	<u>0</u>
D. Operating Expenses	<u>0</u>	<u>0</u>	<u>0</u>
1. Salaries and Wages	<u>0</u>	<u>0</u>	<u>0</u>
2. Physician's Salaries and Wages	<u>0</u>	<u>0</u>	<u>0</u>
3. Supplies	<u>0</u>	<u>0</u>	<u>0</u>
4. Taxes	<u>0</u>	<u>0</u>	<u>0</u>
5. Depreciation	<u>0</u>	<u>0</u>	<u>0</u>
6. Rent	<u>0</u>	<u>0</u>	<u>0</u>
7. Interest, other than Capital	<u>0</u>	<u>0</u>	<u>0</u>
8. Other Expenses (Specify) _____	<u>0</u>	<u>0</u>	<u>0</u>
Total Operating Expenses	<u>0</u>	<u>0</u>	<u>0</u>
E. Other Revenue (Expenses)-Net (Specify)	<u>0</u>	<u>0</u>	<u>0</u>
NET OPERATING INCOME (LOSS)	<u>0</u>	<u>0</u>	<u>0</u>
F. Capital Expenditures			
1. Retirement of Principal	<u>0</u>	<u>0</u>	<u>0</u>
2. Interest	<u>0</u>	<u>0</u>	<u>0</u>
Total Capital Expenditure	<u>0</u>	<u>0</u>	<u>0</u>
NET OPERATING INCOME (LOSS)			
LESS CAPITAL EXPENDITURES	<u>0</u>	<u>0</u>	<u>0</u>

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this project. The fiscal year begins in January (month).

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	Yr-1	Yr-2
A. Utilization/Occupancy Rate (<i>surgical patients</i>)	<u>130</u>	<u>170</u>
B. Revenue from Services to Patients		
1. Inpatient Services		
2. Outpatient Services	<u>1,950,000</u>	<u>2,550,000</u>
3. Emergency Services		
4. Other Operating Revenue (Specify) _____		
Gross Operating Revenue	<u>1,950,000</u>	<u>2,550,000</u>
C. Deductions from Operating Revenue		
1. Contractual Adjustments	<u>987,500</u>	<u>1,275,000</u>
2. Provision for Charity Care	<u>108,625</u>	<u>137,500</u>
3. Provision for Bad Debt	<u>98,750</u>	<u>127,500</u>
Total Deductions	<u>1,194,875</u>	<u>1,540,000</u>
NET OPERATING REVENUE	<u>755,125</u>	<u>1,010,000</u>
D. Operating Expenses		
1. Salaries and Wages	<u>151,120</u>	<u>154,400</u>
2. Physician's Salaries and Wages (Medical Director)	<u>210,000</u>	<u>223,000</u>
3. Supplies	<u>23,000</u>	<u>28,000</u>
4. Taxes	<u>18,000</u>	<u>20,000</u>
5. Depreciation	<u>10,000</u>	<u>10,000</u>
6. Rent	<u>48,000</u>	<u>48,000</u>
7. Interest, other than Capital		
8. Management Fees		
a. Fees to Affiliates		
b. Fees to non-Affiliates		
9. Other Expenses (Specify) <u>See following page</u>	<u>98,800</u>	<u>100,600</u>
Total Operating Expenses	<u>558,920</u>	<u>584,000</u>
E. Other Revenue (Expenses)-Net (Specify)		
NET OPERATING INCOME (LOSS)	<u>196,205</u>	<u>426,000</u>
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest (on Letter of Credit)		
Total Capital Expenditure		
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	<u>196,205</u>	<u>426,000</u>

OTHER EXPENSES
(line D.8, Projected Data Chart)

Other Expenses	Yr-1	Yr-2
Insurance	13,500	13,500
Utilities	2,400	2,700
Accounting	6,000	6,000
Computer Consulting	2,400	2,400
Bank Fees	1,500	1,500
Permits/Licenses	12,500	12,500
Training/Seminars	10,000	10,000
Purchased Services	12,000	12,000
Equipment	16,000	16,000
Janitorial	24,000	24,000
TOTAL (line D.8)	98,800	100,600

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: See (rounded) projected figures below for Year 1:

\$	15,000	Average Gross Charge per procedure
\$	9,191	Average Deduction from Operating Revenue per procedure
\$	5,809	Average Net Charge per procedure.

The above charges are facility charges, only. Clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy, and anesthesiologists, will bill for their own respective services. The Applicant has no control over the billing or participating insurance providers for these clinical professionals. No post-outpatient MUA services are required.

Again, patients will be charged one fee, but this one fee is for a three-day process. The procedure is completed in 3 days in a row as a way of controlling arthrokinetic dyskinesia which has caused fibroblastic proliferative changes. (Please refer to Chapter 2 of Gordon, R. "Manipulation Under Anesthesia, Concepts In Theory and Application"). Since the reference states that adhesions (fibroblastic proliferative changes) will reform in 24-48 hours if left unattended (Guyton, Alter, Koltke), serial MUA performed successively in a three-day format, completed independently on each of the successive days, is how this procedure releases the adhesion proliferation, and continues to resolve the patients aberrant biomechanical pathology.

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: There are no current charges. See (rounded) projected figures below for Year 1:

\$	15,000	Average Gross Charge per procedure
\$	9,191	Average Deduction from Operating Revenue per procedure
\$	5,809	Average Net Charge per procedure.

The above charges are facility charges, only. Clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy, and anesthesiologists, will bill for their own respective services. The Applicant has no control over the billing or participating insurance providers for these clinical professionals. No post-outpatient MUA services are required.

Again, patients will be charged one fee, but this one fee is for a three-day process. The procedure is completed in 3 days in a row as a way of controlling arthrokinetic dyskinesia which has caused fibroblastic proliferative changes. (Please refer to Chapter 2 of Gordon, R. "Manipulation Under Anesthesia, Concepts In Theory and Application"). Since the reference states that adhesions (fibroblastic proliferative changes) will reform in 24-48 hours if left unattended (Guyton, Alter, Koltke), serial MUA performed successively in a three-day format, completed independently on each of the successive days, is how this procedure releases the adhesion proliferation, and continues to resolve the patients aberrant biomechanical pathology.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: There are no similar facilities in the area. The facilities approved in both Knoxville and Nashville have not reported JAR data. However, those two applications had similar projections as to average gross charge, average deductions, and average net charges.

Some of the more common CPT-4 codes are as follows:

- 22505 Spine
- 27275 Hips
- 23700 Shoulders
- 27194 Pelvic Ring Subluxation
- 24300 Elbows
- 26340 Finger Joints
- 27870 Knees
- 27860 Ankles

MUA has been included in the AMA's CPT publications for over 25 years. MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it can not be and is not recognized by legal definition as an experimental or investigational procedure. Insurance carriers that are designating MUA of any area as experimental or investigational have the burden of proof to defend their position that this procedure is experimental. To date, such attempts have been unsuccessful in a court of law. Therefore, since MUA is considered a category 1 procedure by CPT, it is neither an experimental nor investigational procedure.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: The Projected Data Chart indicates sufficient income to maintain cost-effectiveness, with a positive cash flow for both projected years. Obviously, income is dependent upon rendering MUA services to a sufficient number of patients. The Applicant believes such will be the case.

Please see *Attachment C.EF.10* for financials.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response: The Projected Data Chart indicates sufficient income to maintain cost-effectiveness, with a positive cash flow for both projected years. Obviously, income is dependent upon rendering MUA services to a sufficient number of patients. The Applicant believes such will be the case.

Please see *Attachment C.EF.10* for financials.

9. **Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.**

Response: This is a new facility, and certification will be sought for Medicare and Medicaid. MUA is a relatively new service in Tennessee, currently approved only in Knoxville. The Applicant believes that both Medicare and Medicaid have payment mechanisms available for manipulation under anesthesia ("MUA") patients. However, whether or not these programs recognize MUA as a reimbursable service, the Applicant will still take patients who qualify for these programs. If these programs do not reimburse for MUA, the Applicant will write off the cost as charity care. Further, the Applicant will take Medicaid (TennCare) patients out of contract if standard provider contracts are not available.

Procedures: It is projected that 130 and 170 MUA procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization of other facilities in other states, coupled with anecdotal information retrieved from several doctors in the mid-state area.

Medicare and TennCare Revenue Projections:

MEDICARE: Certification will be sought for Medicare. While Medicare has a reimbursement mechanism for MUA, the majority of Medicare patients may have medical conditions that are contraindicated for MUA. In effect, most aged patients have systemic problems that preclude them from being candidates for MUA procedures. Therefore, the Applicant believes that Medicare patients will be such a small percentage of patients (15%). If reimbursement is available, such application will be sought. If reimbursement is not available, the procedures will be written off as charity care. The main factor in taking such patients will be whether or not each patient is a candidate for MUA based on his/her respective medical condition.

TENNCARE: Certification will be sought for TennCare. The Applicant understands that Medicaid reimburses for MUA procedures, and believes that TennCare will, also. The Applicant will take any TennCare patients out of network. If reimbursement is not available, the procedures will be written off as charity care. Again, the main factor in taking such patients will be whether or not each patient is a candidate for MUA based on his/her respective medical condition.

While there are CPT codes for various MUA procedures, we are not sure if reimbursement will be available for such patients until such time as we actually provide the procedures and submit the claims for payment. In the meantime, we plan to provide MUA services to Medicare and TennCare patients in any regard, and if reimbursement is not available, we will simply declare such services as charity care. We are aware of several insurance companies that reimburse for MUA care, but reimburse at discounted rates.

MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it can not be and is not recognized by legal definition as an experimental or investigational procedure. Insurance carriers that are designating MUA of any area as experimental or investigational have the burden of proof to defend their position that this procedure is experimental. To date, such attempts have been unsuccessful in a court of law. Therefore, since MUA is considered a category 1 procedure by CPT, it is neither an experimental nor investigational procedure.

The Applicant does anticipate contractual adjustments from insurance companies, and has allowed for that in the Projected Data Chart.

- 10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.**

Response: Since the ASTC is not operational or licensed, financials of the Applicant reflect the private practice of the Owner of the Applicant. See *Attachment C.EF.10*.

11. **Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:**
- a. **A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.**

Response: There were no other viable alternatives considered, other than to do nothing. Doing nothing would not provide a viable alternative for the treatment of patients with chronic pain. Patients that have failed standard of care procedures, including conscious manipulation, qualify for the treatment offered under the MUA.

Physicians have expressed concern about the treatment of chronic pain. Chronic pain has both chemical and mechanical components. Such treatment is difficult, sometimes ineffective, and has risks. These risks include narcotic abuse, misuse and diversion, and infection (such as Epidural Steroid Injections). There appears to be general consensus that a procedure that could significantly lower pain scores, improve functional capacity, and reduce narcotic use would be invaluable in the treatment of chronic pain. MUA is such a procedure.

Manipulation under anesthesia (“MUA”) is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the early 1930s. The process involves relaxing the patient (with anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

The space for the specialty ASTC is available and will be sub-leased. Therefore, the purchase of land and construction of a new facility was not even considered, as it would have been cost-prohibitive.

- b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.**

Response: There were no other viable alternatives considered, other than to do nothing. Doing nothing would not provide a viable alternative for the treatment of patients with chronic pain. Patients that have failed standard of care procedures, including conscious manipulation, qualify for the treatment offered under the MUA.

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CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. **List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

Response: The Applicant has working relationships but no formal contractual relationships with any other providers, as contemplated by this question. If needed, agreements will be implemented. For the time being, it is not anticipated that such agreements will be necessary. In case of emergency, the clinic's site is close to Memphis area hospitals. Both Doctors of Chiropractic and either Medical Doctors or Doctors of Osteopathy will be on site when MUA procedures are provided.

Those entities with which the Owner has working relationships are:

Medicine Bartlett Internal
Campbell Clinic
Dr. Emmanuel Hoh
Dr. Hettie Gibbs
Dr. Jerry Lovelace
Dr. Michael Lemonds
Getwell Community Health
Health Loop
Medplex
Midtown Injury and Patient Center
Oakland Clinic
Primary Care specialists
Prime Urgent Care
Somerville Medical Clinic
Total Health and Wellness.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response: The approval of this application should not have a material adverse impact on any health care providers in the western part of Tennessee. There are no other facilities dedicated to the provision of MUA procedures, and the Applicant is not aware of any data that would indicate any existing providers (hospitals or ASTCs) are already providing these procedures.

Although not comparable to this project, utilization and charge information for hospitals and existing ASTCs in the service area are provided as cumulative *Attachment C.OD.2*.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. It should be assumed that existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. Please see *Attachment C.OD.3* for a list of sample wage information for the service area.

Proposed staff include an administrator, a coordinating clerk, and RN. The RN will be paid approximately \$47,000 per year. The anesthesiologist and/or CRNA will bill for services separately, as will the physicians. The Applicant plans on working with area training programs to allow students to rotate through our facility to complete clinical training requirements. Further, doctors will be trained in the clinic.

Support personnel are already available for this project. In addition to the RN, the following will staff the ASTC:

<u>FTE</u>	<u>Staff</u>	<u>Salary Range</u>	<u>Availability</u>
1.0	Administrator	\$30,000	On Staff at Owner.
2.0	Clerical	\$20,000	On Staff at Owner.
1.0	RN	\$47,000	Will be Employed

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. It should be assumed that existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. Please see *Attachment C.OD.3* for a list of sample wage information for the service area.

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2.0	Clerical	\$20,000	On Staff at Owner.
1.0	RN	\$47,000	Will be Employed

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs*, record keeping, and staff education.**

Response: The Applicant is familiar with licensing certification requirements for an ASTC. This Application is for a Specialty ASTC, and certain waivers will be requested as no operative surgical procedures will take place.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).**

Response: The Applicant has every intention of working with both the HSDA and the Tennessee Department of Health, Division of Licensing Health Care Facilities, to coordinate useful licensing requirements and utilization standards for facilities such as is proposed in this application. In fact, a representative of the Applicant has already met with representatives of the Board for Licensing Health Care Facilities in this regard. Please see *Attachment C.N.5* for a draft of working protocols for MUA procedures. Note that all physicians who perform these procedures at our clinic must have achieved at least 36 hours of postgraduate instruction in MUA from a CCE/CME accredited Chiropractic or Medical School. This training covers an array of instruction areas, including but not limited to, the history of MUA procedures, the scientific basis of the MUA procedure, the clinical application of the patients for MUA, the proper selection of patients for MUA, clinical (hands-on) training, and both oral and written examinations. Robert C. Gordon, D.C., the previously-mentioned consultant, is already training doctors in Tennessee for MUA procedures and has trained doctors in other states for years. In fact, he has trained all of the doctors affiliated with this project.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response: The Applicant is familiar with licensing certification requirements for an ASTC. This Application is for a Specialty ASTC, and certain waivers will be requested as no operative surgical procedures will take place.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Response:

Licensure: Tennessee Department of Health.

Accreditation: Medicaid, Medicare, TennCare.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response: Not applicable.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response: Not applicable.

- 8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Response: There have been no final orders or judgments as are contemplated by this question.

- 9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project**

Response: There have been no final orders or judgments as are contemplated by this question.

- 10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

Response: The Applicant will provide all data contemplated by this question.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response: Please see attached tear sheet from the December 10, 2012 edition of *The Commercial Appeal*

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the “good cause” for such an extension.

Form HF0004
Revised 05/03/04
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): 12/2010.

Assuming the CON approval becomes the final agency action on that date; indicate the number of day **from the above agency decision date** to each phase of the completion forecast.

<u>Phase</u>	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	<u>0</u>	<u>0</u>
2. Construction documents approved by the Tennessee Department of Health	<u>120</u>	<u>07/13</u>
3. Construction contract signed	<u>30</u>	<u>08/13</u>
4. Building permit secured	<u>30</u>	<u>09/13</u>
5. Site preparation completed	<u>30</u>	<u>10/13</u>
6. Building construction commenced	<u>30</u>	<u>11/13</u>
7. Construction 40% complete	<u>30</u>	<u>12/13</u>
8. Construction 80% complete	<u>30</u>	<u>01/14</u>
9. Construction 100% complete (approved for occupancy)	<u>30</u>	<u>02/14</u>
10. *Issuance of license	<u>30</u>	<u>03/14</u>
11. *Initiation of service	<u>30</u>	<u>04/14</u>
12. Final Architectural Certification of Payment	<u>1</u>	<u>04/14</u>
13. Final Project Report Form (HF0055)	<u>30</u>	<u>05/14</u>

*** For projects that do NOT involve construction or renovation : Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

2012 DEC 14 AM 10 30

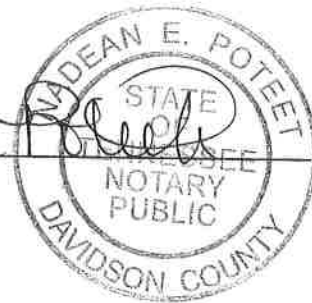
E. Graham Baker, Jr., being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

E. Graham Baker, Jr. /Attorney
SIGNATURE/TITLE

Sworn to and subscribed before me this 14th day of December, 2012, a
(month) (year)

Notary Public in and for the County/State of Davidson/Tennessee.

Nadean E. Poteet
NOTARY PUBLIC



My commission expires May 6th, 2013.
(Month/Day) (Year)

ASTC Specific Criteria

Following are responses to the specific criteria for Ambulatory Surgical Treatment Centers on pages 51/52 of Tennessee's Health: Guidelines for Growth:

1. *The need for an ambulatory surgical treatment center shall be based upon the following assumptions:*
 - a. *An operating room is available 250 days per year, 8 hours per day.*
 - b. *The average time per outpatient surgery case is 60 minutes.*
 - c. *The average time for clean up and preparation between outpatient surgery cases is 30 minutes.*
 - d. *The capacity of a dedicated, outpatient, general-purpose operating room is 80% of full capacity. That equates to 800 cases per year.*
 - e. *Unstaffed operating rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.*

Response: This application is for a one procedure room Specialty ASTC providing MUA services, only, and its utilization is not comparable to dedicated, outpatient, general-purpose operating rooms. Therefore, much of the data required for this question is not available and not applicable.

This is a relatively new procedure (manipulation under anesthesia, or "MUA"), and we simply have no history to document utilization except for anecdotal information. Approximately five of these procedures can be performed in one day. A sterile operating room is not required, and this application is for one "clean" procedure room. As the Applicant anticipates performing only about 390 procedures during the first year (130 patients, with each patient receiving one procedure per day on three successive days), it is anticipated that the procedure room will not be utilized anywhere near the 250 days suggested in the guidelines. In fact, with the guideline capacity of outpatient procedure rooms at 800 procedures per year and the Applicant planning to perform only 390 procedures per year (130 patients receiving 3 procedures each), the one procedure room will be utilized approximately 16% of the time (utilizing the new "cases/patients/encounters" definition of "procedures"). As the space is available, the procedure room can be "available" 250 days per year, but the number of procedures anticipated will surely not warrant such suggested utilization – at least not initially.

MUA procedures can be performed within 60 minutes, and clean-up and preparation time between procedures will not exceed 30 minutes.

ASTC Specific Criteria

2. *“Service Area” shall mean the county or counties represented by the applicant as the reasonable area to which the facility intends to provide services and/or in which the majority of its service recipients reside.*

Response: See *Attachment C.N.3* for a map of the proposed service area.

The Applicant’s service area consists of Shelby, Fayette and Tipton Counties.

It is important to note that the service area for this project is based, in large part, on the actual patient origin information for the Owner of the Applicant, plus those other area chiropractors either affiliated with or contacted by the Owner.

3. *The majority of the population of a service area for an ambulatory surgical treatment center should reside within 30 minutes travel time to the facility.*

Response: The majority of residents within these three counties reside within 30 minutes travel time of the site of the proposed facility.

ASTC Specific Criteria

4. All applicants should demonstrate the ability to perform a minimum of 800 operations and/or procedures per year per operating room and/or procedure room. This assumes 250 days x 4 surgeries/procedures x .80.

Response: This application is for a one procedure room Specialty ASTC providing MUA services, only, and its utilization is not comparable to dedicated, outpatient, general-purpose operating rooms. Therefore, much of the data required for this question is not available and not applicable.

This is a relatively new procedure (manipulation under anesthesia, or “MUA”), and we simply have no history to document utilization except for anecdotal information. Approximately five of these procedures can be performed in one day. A sterile operating room is not required, and this application is for one “clean” procedure room. As the Applicant anticipates performing only about 390 procedures during the first year (130 patients, with each patient receiving one procedure per day on three successive days), it is anticipated that the procedure room will not be utilized anywhere near the 250 days suggested in the guidelines. In fact, with the guideline capacity of outpatient procedure rooms at 800 procedures per year and the Applicant planning to perform only 390 procedures per year (130 patients receiving 3 procedures each), the one procedure room will be utilized approximately 16% of the time (utilizing the new “cases/patients/encounters” definition of “procedures”). As the space is available, the procedure room can be “available” 250 days per year, but the number of procedures anticipated will surely not warrant such suggested utilization – at least not initially.

It is also important to note that an ASTC limited to MUA procedures was approved by the HSDA in early 2009. That project was not completed, so the need for an ASTC limited to MUA procedures still exists.

ASTC Specific Criteria

5. *A certificate of need (CON) proposal to establish a new ambulatory surgical treatment center or to expand the existing services of an ambulatory surgical treatment center shall not be approved unless the existing ambulatory surgical services within the applicant's service area or within the applicant's facility are demonstrated to be currently utilized at 80% of service capacity. Notwithstanding the 80% need standard, the Health Facilities Commission (sic) may consider proposals for additional facilities or expanded services within an existing facility under the following conditions: proposals for facilities offering limited-specialty type programs or proposals for facilities where accessibility to surgical services is limited.*

Response: This application is for a Specialty ASTC, and its utilization is not comparable to dedicated, outpatient, general-purpose operating rooms. Therefore, this is not applicable. However, special attention should be given to the fact that MUA is a relatively new procedure for Tennessee.

MUA is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the 1930s. Leading references put the use of MUA in the United States as far back as 1938, when Persols International Medical Clinic from Great Britain brought the procedures to the United States through Doctors Shiel, Clauborne, Mensor, and others, as reported in the Bibliography in the textbook, "Manipulation Under Anesthesia, Concepts In Theory and Application," Gordon, R., et.l., Taylor and Francis, April 2005. The process involves relaxing the patient (with anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

MUA also includes MUJA, which stands for Manipulation Under Joint Anesthesia, and involves injecting anti-inflammatory medication into painful inflamed joints both in conjunction with the biomechanical alterations accomplished with the MUA techniques, and as a screening tool. Patients suffering more severe or complex joint pain have a better response to the MUA techniques when afforded this medication. However, if such a joint injection completely alleviates the pain, such blocks may well preclude the need for additional MUA procedures for some patients. In effect, MUJA procedures are part of the MUA continuum of care.

MUA procedures must be performed in a designated area where anesthesia is provided. To do that, a facility must meet the basic needs of a proper room, life support, room for the movement of the physicians involved in the procedure, as well as room for the nursing staff and the anesthesiologist. The designation of a "clean room" can be used in this case since this procedure does not require a sterile environment. The Applicant believes that such procedures should be administered in a licensed, regulated environment by licensed, regulated physicians to ensure proper protocols are followed, thereby ensuring that the procedures are performed correctly, keeping in mind the patients' health.

ASTC Specific Criteria

While MUA procedures could have been conducted in a physician's office in the past, such is not desirable for the reasons stated above. There is no current licensure designation for a clinic in which to perform MUA procedures, only. However, according to the Board for Licensing Health Care Facilities, Department of Health, such procedures could be performed in a "specialized" ASTC. Therefore, the Applicant is applying for a specialized ASTC, limiting the procedures to be performed to MUA, only.

A decision by the Board of Chiropractic Examiners would have the effect of limiting MUA procedures to certified facilities, so "in-office" procedures are a thing of the past. On February 21, 2008, the Board of Chiropractic Examiners adopted the following position statement:

"A licensed Tennessee chiropractor may provide chiropractic services to a patient who is under anesthesia if and only if:

- (1) The chiropractic physician has received certification from an institution accredited by the Council on Chiropractic Education (CCE) and pursuant to a course of study recognized by the National Manipulation Under anesthesia (MUA) Academy of Physicians and/or the International MUA Academy of Physicians; and
- (2) The anesthesia is administered in a facility properly equipped and certified as required by law to administer anesthesia; and
- (3) The anesthesia is administered by – and the anesthetized patient is at all times monitored by – an anesthesiologist or other healthcare professional who is legally qualified to perform and monitor anesthesia."

This Applicant will comply with this position statement.

MUA is within the scope of practice of DCs, MDs and DOs in all states. The Applicant (through its consultant) is aware of MUA being performed in licensed facilities in New Jersey, New York, Missouri, Kentucky, Texas, Montana, California, Utah, Florida, Oklahoma, Kansas, Louisiana, South Carolina, Arizona, and, now, Tennessee.

According to Dr. Robert C. Gordon, a nationally-recognized leader in the provision of MUA (See *Attachment B.II.A* for a curriculum vitae'), the risks over the past 20 years of performing this technique have been very minimal. Most of the occurrences have been limited to patient reaction to anesthesia, not following proper anesthesia protocols (being NPO 6-8 hours before the procedure), and to the selection of patients who are inappropriate candidates for MUA. This is the reason for the Applicant's insistence on rigorous training required by the physicians performing the procedure, including testing and proctoring before receiving a certificate of training. This is also the reason that the specific training that has been sited in this application is more accountable than other

ASTC Specific Criteria

training programs that may be out there. (Also, please see *Attachment B.II.A.1* for copies of three case studies on MUA).

Physicians have expressed concern about the treatment of chronic pain. Chronic pain has both chemical and mechanical components. Such treatment is difficult, sometimes ineffective, and has risks. These risks include narcotic abuse, misuse and diversion, and infection (such as when utilizing Epidural Steroid Injections). There appears to be general consensus that a procedure that could significantly lower pain scores, improve functional capacity, and reduce narcotic use would be invaluable in the treatment of chronic pain. MUA is such a procedure.

X-rays are performed on every patient by the referring chiropractor, and will occur well in advance of the patient being referred to the facility. In some cases, MRI procedures will also be performed. Such diagnostic tests have to be performed in order to determine whether or not the patient is a candidate for MUA procedures. However, such diagnostic exams are not part of this project.

According to Dr. Gordon, Doctors of Chiropractic average seeing approximately 110 patients per week, and about 5% of those patients are candidates for MUA due to chronic pain. Once MUA procedures are administered, only about 0.5% of all MUA cases are considered repeatable. This is due to properly selecting the right cases for the procedure based on the NAMUAP standards and Protocols. Following the 3-day procedure, patients are shown physical therapy exercises and stretching methods in order to maintain optimal health.

The average age range for traditional MUA patients is approximately 25-62, but is not specifically limited to this age group. A brief explanation of the process to be followed is as follows:

1. Patients will need three procedures on three successive days (they will be transported to/from the facility, negating the need for overnight stays at the ASTC);
2. Patients will enter through the Reception area;
3. The patient is taken to a room to complete paperwork and receive final instructions on the procedure;
4. The actual procedure is performed in the Procedure Room;
5. The patient will then go to the Recovery Room;
6. Each patient will then receive post-therapeutic treatment;
7. And then be taken from the facility.

It is also important to note that only one patient will be under anesthesia at a time, and that patient will be attended to by at least one chiropractic doctor and at least one (either) medical doctor or doctor of osteopathy during the entire time the patient is unconscious. Anesthesia will be administered by either an Anesthesiologist or a CRNA working for an Anesthesiologist. Further, an RN will also attend the patient at all times.

ASTC Specific Criteria

Patients must have medical clearance for anesthesia. Also, patients have to have had testing for the procedure (standard testing is CBS/Diff and sometimes an SMA6). If the patient is over 50 years of age, he/she will need an EKG; if the patient has a history of respiratory difficulty, a Chest X-Ray will be required. Finally, a pregnancy test will be given to female patients.

Both the person administering anesthesia and the recovery room nurse must be ACLS certified in life support. Following the MUA procedure, each patient will go to the Recovery Room for gentle stretching and physical therapy, including Interferential (electrical stimulation) therapy, and then ice. Following this, the patient will have a massage prior to discharge. The time for such post-therapeutic care must be designated only by the condition of each patient. It is not a probable assumption to conclude that all persons receiving post MUA therapy would receive the exact same amount of therapy, since the conditions that they have would vary from one patient to another. Following the procedure, most patients are fully capable of ambulation. However, it is advised that someone (either our staff, a family member, or friend) drive the patient to their destination in order for the patient to receive rest and relaxation.

The Applicant will lease the physical space and own the equipment. As limited staff are needed, the Applicant anticipates no problem in securing appropriate staff for the operation of the ASTC.

Since MUA is a relatively new procedure to be regulated in Tennessee, there are no comparable facilities in Tennessee with which to compare utilization, or to gather any other forms of comparable data. While two facilities are already approved (in Nashville and Knoxville), utilization data (such as would be contained in JARs) is not available. Since MUA procedures have been performed since the 1930s, it is assumed that they were being performed, albeit to a limited extent, in Tennessee. However, there exists no data for such procedures if they were performed, at all.

Proposed staff include an administrator, a coordinating clerk, and RN. Administrative staff is already available on staff of the Owner. The RN will be paid approximately \$47,000 annual salary. The anesthesiologist and/or CRNA will bill for services separately, as will the physicians. The Applicant plans on working with area training programs to allow students to rotate through our facility to complete clinical training requirements. Further, doctors will be trained in the clinic.

The Applicant anticipates an average gross charge per patient in Year 1 of operation of \$15,000, with an average deduction of approximately \$9,191, for an average net charge of approximately \$5,808 per patient. Projections indicate positive cash flow the first two years of operation (see Projected Data Chart).

It is projected that 130 and 170 MUA procedures will be performed in years 1 and 2, respectively. These projections are based on statistical projections of chiropractic practices, coupled with anecdotal information retrieved from several doctors in the area.

ASTC Specific Criteria

The Applicant projects that approximately 15% of the total patients will be Medicare, and approximately 80% will be Medicaid/TennCare. The remaining 5% are expected to be Commercial Insurance patients. The Applicant does anticipate contractual adjustments from insurance companies, and has allowed for that in the Projected Data Chart.

Unfortunately, there still remain a few insurance companies that consider MUA an experimental or investigative procedure. Some providers have surmised that an insurance company receives monthly premiums from policy holders and is supposed to pay for covered procedures if and when the policy holders submit claims. The more claims that are paid, the less profit for the insurance company. If the insurance company does not want to pay the claim, there are several responses to such claims which either decrease the possibility of paying the claim, or at least, delay the payment. These responses include, but are not limited to, "You aren't covered; this procedure isn't covered; this procedure is experimental; the paperwork for the claim isn't completed properly; the claimant had a pre-existing condition which was not divulged on the application form; we have no record of your claim;" etc. Any delay is a delay.

However, it is a fact that MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it can not be and is not recognized by legal definition as an experimental or investigational procedure. Insurance carriers that are designating MUA of any area as experimental or investigational have the burden of proof to defend their position that this procedure is experimental. To date, such attempts have been unsuccessful in a court of law. Therefore, since MUA is considered a Category 1 procedure by CPT, it is neither an experimental nor an investigational procedure.

ASTC Specific Criteria

6. *A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment (sic) must specify the number of projected surgical operating rooms to be designated for ambulatory surgical services.*

Response: The Applicant proposes one procedure room for this Specialty ASTC. MUA procedures must be performed in a designated area where anesthesia is provided. To do that, a facility must meet the basic needs of a proper room, life support, room for the movement of the physicians involved in the procedure, as well as room for the nursing staff and the anesthesiologist. The designation of a “clean room” can be used in this case since this procedure does not require a sterile environment. The Applicant believes that such procedures should be administered in a licensed, regulated environment by licensed, regulated physicians to ensure proper protocols are followed, thereby ensuring that the procedures are performed correctly, keeping in mind the patients’ health.

7. *A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first specify the number of project eight quarters following the completion of the proposed project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.*

Response: It is projected that 130 and 170 MUA procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization of other facilities in other states, coupled with anecdotal information retrieved from several doctors in the mid-state area.

Attempts to project the number of patients to be seen by quarter will be nothing more than an estimate, as there are no existing MUA ASTCs in the state, and startup utilization has never been documented in the state. Common sense dictates that the number of procedures will be lower initially and then increase as the medical community and the public at large become more educated about MUA services. With that in mind, a fair estimation of patient utilization, by quarter, would be: 26, 30, 35, 39, 40, 41, 43, 47. The previous quarterly estimates are not based on specific methodology due to the unique nature of the procedure, and the fact none have been performed in MUA ASTCs in the state in the past year, so far as can be documented through JARs.

ASTC Specific Criteria

8. *A CON proposal to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient origin by percentage and county of residence. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.*

Response: See *Attachment C.N.3* for a map of the proposed service area.

The Applicant's service area consists of Shelby, Fayette and Tipton Counties.

It is important to note that the service area for this project is based, in large part, on the actual patient origin information for the Owner of the Applicant, plus those other area chiropractors either affiliated with or contacted by the Owner.

This question anticipates that an applicant will know exactly the county of residence for all projected patients. Such is not the case with this relatively new procedure called manipulation under anesthesia ("MUA"). MUA is a treatment for patients with severe pain. As such, common sense and historic utilization of other such MUA centers dictates that such patients will avail themselves of, and are more proper candidates for, MUA services – more so than the general population. With that in mind and based on historic patient origin at the Applicant's Owner., the Applicant anticipates that Shelby County will provide the most patients of any county in the service area, followed by Tipton County and Fayette County. These estimations are also guided by the number of chiropractors in each county (134, 7, and 1, respectively).

As the medical community and the public at large become more educated about MUA services, it is fully anticipated that patients from other areas will gravitate to the Applicant's ASTC. The extent of future patient origin is unknown at this time, and cannot be documented, as there are no MUA ASTCs in the state.

Secretary of State
Division of Business Services
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

JAN - 5 2004 Attachment A.4

DEC 18 2003

DATE: 12/15/03
REQUEST NUMBER: 4984-0656
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 12/15/03 1041
EFFECTIVE DATE/TIME: 12/15/03 1630
CONTROL NUMBER: 0292714

TO:
LONDON AMBURN & LLOYD PC
1716 CLINCH AVE
PATTI COTTEN ESQ
KNOXVILLE, TN 37916

RE:
SPINAL HEALTH CARE ASSOCIATES, P.C.
AMENDED AND RESTATED CHARTER

THIS WILL ACKNOWLEDGE THE FILING OF THE ATTACHED DOCUMENT WITH AN EFFECTIVE DATE AS INDICATED ABOVE.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE CORPORATION CONTROL NUMBER GIVEN ABOVE.

PLEASE BE ADVISED THAT THIS DOCUMENT MUST ALSO BE FILED IN THE OFFICE OF THE REGISTER OF DEEDS IN THE COUNTY WHEREIN A CORPORATION HAS ITS PRINCIPAL OFFICE IF SUCH PRINCIPAL OFFICE IS IN TENNESSEE.

FOR: AMENDED AND RESTATED CHARTER

ON DATE: 12/15/03

FROM:
LONDON & AMBURN (1716 CLINCH AVE)
1716 CLINCH AVENUE

KNOXVILLE, TN 37916-0000

RECEIVED: FEES \$20.00 \$0.00
TOTAL PAYMENT RECEIVED: \$20.00

RECEIPT NUMBER: 00003394554
ACCOUNT NUMBER: 00134919

Riley C. Darnell

RILEY C. DARNELL
SECRETARY OF STATE



AMENDED AND RESTATED
CHARTER OF
SPINAL HEALTH CARE ASSOCIATES, P.C.

The undersigned professional corporation (the "Corporation") hereby amends and restates its Charter pursuant to Section 48-20-107 of the Tennessee Business Corporation Act by deleting the text of the current Charter (and all amendments thereto) and replacing it with the following:

1. The name of the Corporation is Spinal Health Care Associates, P.C.
2. The Corporation is authorized to issue ten thousand (10,000) common shares, which shares collectively shall have unlimited voting rights and the right to receive the net assets of the Corporation upon dissolution.
3. The street address of the Corporation's registered office is:

1025 Cordova Station
Cordova, Tennessee 38018
4. The Corporation's registered agent in the registered office is Rock A. Wooster,
D.C.
5. The street address of the Corporation's principal office is:

1025 Cordova Station
Cordova, Tennessee 38018
7. The Corporation is for profit.
8. The Corporation is a professional corporation and hereby elects to be governed by the provisions of the Tennessee Professional Corporation Act (the "Act").
9. The purposes of the Corporation are to engage in the practice of medicine and render chiropractic services, which shall include without limitation the performance of other services related to the practice of chiropractic and medicine and all other things necessary or appropriate to carry out such purpose, and to engage in any other lawful and related business activities, consistent with the provisions of the Act.
10. No director of the Corporation shall be personally liable to the Corporation or its shareholders for monetary damages for breach of fiduciary duty as a director, except: (i) for any breach of the director's duty of loyalty to the Corporation or its shareholders; (ii) for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law; or (iii) under Tennessee Code Annotated Section 48-18-304.

FILED
RECEIVED
NOV 15 AM 10:41
TENN
SECRETARY OF STATE

11. The shares of the Corporation shall only be issued to, held by, or transferred to a person who is licensed by the State of Tennessee to practice chiropractic or medicine except as otherwise permitted under the provisions of the Tennessee Professional Corporation Act, and each certificate for shares of the Corporation shall be appropriately endorsed disclosing such restriction and stating that shares standing in the name of a retired person or of a person disqualified to practice medicine, or in the name of the personal representative of a deceased person, except during the holding period provided by the provisions of the Tennessee Professional Corporation Act, are void.

Dated this 11 day of December, 2003.

Spinal Health Care Associates, P.C.

By: Fred E. King, M.D.
Fred E. King, M.D.
President

CERTIFICATE AND VERIFICATION

To comply with the requirements of Tennessee Code Annotated Section 48-20-107(d), Spinal Health Care Associates, P.C. (the "Corporation") certifies (a) that the foregoing Amended and Restated Charter of the Corporation contains amendments requiring Shareholder approval, (b) that such amendments deleted the text of the charter and replaced it with the text of the Amended and Restated Charter, and (c) that the Amended and Restated Charter was duly adopted by the Board of Directors and Shareholders of the Corporation on December 1, 2003.

Dated this _____ day of December, 2003.


Spinal Health Care Associates, P.C.

By: Fred E. King
Fred E. King, M.D.,
President



Tom Leatherwood
Shelby County Register

As evidenced by the instrument number shown below, this document
has been recorded as a permanent record in the archives of the
Office of the Shelby County Register.

	
03252441	
12/31/2003 - 12:49 PM	
4 PGS : R - CHARTER AMENDMENT IN STAT	
ERICA 195407-3252441	0.00
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	5.00
DP FEE	2.00
REGISTER'S FEE	0.00
WALK THRU FEE	0.00
TOTAL AMOUNT	7.00
TOM LEATHERWOOD	
REGISTER OF DEEDS SHELBY COUNTY TENNESSEE	



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **SPINAL HEALTH CARE ASSOCIATES, P.C.**

General Information

Control # :	292714	Formation Locale:	TENNESSEE
Filing Type:	Corporation For-Profit - Domestic	Date Formed:	03/30/1995
Filing Date:	03/30/1995 10:38 AM	Fiscal Year Close	3
Status:	Active		
Duration Term:	Perpetual		
Business Type:	Professional Corporation		

Registered Agent Address

ROCK A WOOSTER D C
STE 102
8132 CORDOVA RD
CORDOVA, TN 38016-6005

Principal Address

STE 102
8132 CORDOVA RD
CORDOVA, TN 38016

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
11/09/2011	Assumed Name New Assumed Name Changed From: No Value To: SHELBY COUNTY PAIN CLINIC	6957-0148
03/08/2011	2011 Annual Report Principal County Changed From: Shelby County To: SHELBY	A0059-2025
12/10/2010	Assumed Name New Assumed Name Changed From: No Value To: Cordova Pain Treatment Center	6802-0499
04/23/2010	2010 Annual Report Principal Address 1 Changed From: 1025 CORDOVA STATION To: 8132 CORDOVA RD Principal Address 2 Changed From: No value To: STE 102 Principal Postal Code Changed From: 38018 To: 38016-0000	6711-1952
04/03/2009	2009 Annual Report	6505-2972
04/16/2008	2008 Annual Report Registered Agent Physical Address Changed Mail Address Changed	6299-0627
03/23/2007	2007 Annual Report	5999-1318

Filing Information

Name: **SPINAL HEALTH CARE ASSOCIATES, P.C.**

10/18/2006	2006 Annual Report	5878-1078
08/31/2006	Notice of Determination	ROLL 5854
03/10/2005	2005 Annual Report	5384-1957
05/03/2004	2004 Annual Report	5126-0764
12/15/2003	Amended and Restated Formation Documents	4984-0656
	Shares of Stock Changed	
	Registered Agent Physical Address Changed	
	Registered Agent Changed	
10/08/2003	2003 Annual Report	4930-0950
09/19/2003	Notice of Determination	ROLL 4915
04/09/2002	2002 Annual Report	4476-0734
03/20/2001	2001 Annual Report	4154-0520
03/13/2000	2000 Annual Report	3850-0819
03/27/1998	CMS Annual Report Update	3482-1243
	Principal Address Changed	
	Mail Address Changed	
04/07/1997	CMS Annual Report Update	3325-0708
	Principal Address Changed	
	Registered Agent Physical Address Changed	
03/17/1997	Administrative Amendment	3306-1581
	Mail Address Changed	
03/30/1995	Initial Filing	2987-1100

Active Assumed Names (if any)

	<u>Date</u>	<u>Expires</u>
SHELBY COUNTY PAIN CLINIC	11/09/2011	11/09/2016
Cordova Pain Treatment Center	12/10/2010	12/10/2015

COMMERCIAL LEASE

This Lease is made on *11-1-2012*, between *Rock A Wooster and Jason Coleman.*, Landlord, of 8132 Cordova Rd. Suite 101, City of *Cordova*, State of *Tennessee*, and *Spinal Health Care Associates P.C.*, Tenant, of 8132 Cordova Rd Suite 101, City of *Cordova*, State of *Tennessee*.

1. The Landlord agrees to rent to the Tenant and the Tenant agrees to rent from the Landlord the following property: ***2100 square feet, property address of 8132 Cordova Rd Suite 101 to be used as an ambulatory surgery center.***
2. The rental payments will be ***\$ 4000.00*** per month and will be payable by the Tenant to the Landlord on the first day of each month, beginning on 11-1-12. If any rental payment is not paid within five (5) days of its due date, the Tenant agrees to pay an additional late charge of 5% (five percent) of the rental payment due.
3. The term of this Lease will be from ***11-1-12***, until ***10-31-15***. If Tenant is in full compliance with all of the terms of this Lease at the expiration of this term, Tenant shall have the option to renew this Lease for an additional term of ***3 years***, with all terms and conditions of this Lease remaining the same, except that the rent shall be ***\$4500.00***. If the Tenant remains as tenant after the expirations of this Lease with the consent of the Landlord but without signing a new lease, a month-to-month tenancy will be created with the same terms and conditions as this Lease, except that such new tenancy may be terminated by ninety (90) days written notice from either the Tenant or the Landlord, and that the rent shall be ***\$4500.00***.
4. The Tenant has paid the Landlord a security deposit of \$ _____. This security deposit will be held as security for the repair of any damages to the property by the Tenant. This deposit will be returned to the Tenant within ten (10) days of the termination of this Lease, minus any amounts needed to repair the property, but without interest.
5. The Tenant has paid the Landlord an additional month's rent in the amount of \$ _____. This rent deposit will be held as security for the payment of rent by the Tenant. This rent payment deposit will be returned to the Tenant within ten (10) days of the termination of this Lease, minus any rent still due upon termination, but without interest.
6. The Tenant agrees to use the property only for the purpose of carrying on the following lawful business:
Ambulatory Surgery Center
7. The Landlord agrees that the Tenant may install the following equipment and fixtures for the purpose of operating the Tenant's business and that such equipment and fixtures shall remain the property of the Tenant:

8. The Tenant has inspected the property and has found it satisfactory for its intended purposes. The Landlord shall be responsible for the repair and the upkeep of the exterior of the property, including the roof, exterior walls, parking areas, landscaping, and building foundation. The Tenant shall be responsible for the repair and upkeep of the interior of the property, including all electrical, mechanical, plumbing, heating, cooling, or any other system or equipment on the property. Tenant agrees to maintain the interior of the property and the surrounding outside are in a clean, safe, and sanitary manner and not to make any alterations to the property without the Landlord's written consent. At the termination of this Lease, the Tenant agrees to leave the property in the same condition as when it was received, except for normal wear and tear. Tenant also agrees to comply with all rules, laws, regulations, and ordinances affecting the property or the business activities of the Tenant.
9. The Tenant agrees to obtain and pay for all necessary utilities for the property.
10. The Tenant agrees not to sub-let the property or assigns this Lease without the Landlord's written consent, which shall not be unreasonably withheld. Tenant agrees to allow the Landlord reasonable access to the property for inspection and repair. Landlord agrees to enter the property only after notifying the Tenant in advance, except in an emergency.
11. If the Tenant fails to pay the rent on time or violates any other terms of this Lease, the Landlord will provide written notice of the violation or default, allowing **10** days to correct the violation or default. If the violation or default is not completely corrected within the time prescribed, the Landlord will have the right to terminate this Lease with **30** days notice and in accordance with state law. Upon termination of this Lease, the Tenant agrees to surrender possession of the property. The Landlord will also have the right to re-enter the property and take possession of it, remove Tenant and any equipment or possessions of Tenant, and to take advantage of any other legal remedies available.
12. The Landlord agrees to carry fire and casualty insurance on the property, but shall have no liability for the operations of the Tenant's business. The Tenant agrees not to do anything that will increase the Landlord's insurance premiums and, further agrees to indemnify and hold the Landlord harmless from any liability or damage, whether caused by Tenant's operations or otherwise. The Tenant agrees to carry and pay all premiums for casualty insurance on any equipment or fixtures that Tenant installs at the property. In addition, the Tenant agrees to carry business liability insurance, including bodily injury and property damage coverage, covering all Tenant's business operations in the amount of **\$1,000,000.00** with the Landlord named as a co-insured party. Tenant agrees to furnish Landlord copies of the insurance policies and to not cancel the policies without notifying the Landlord in advance. Tenant agrees to provide Landlord with a Certificate of Insurance which indicates that Landlord is a co-insured party and that Landlord shall be provided with a minimum of (10) day's written notice prior to cancellation or change of coverage.

13. This Lease is subject to any mortgage or deed of trust currently on the property or which may be made against the property at any time in the future. The Tenant agrees to sign any documents necessary to subordinate this Lease to a mortgage or deed of trust for the Landlord.
14. This Lease may only be terminated by **60** days written notice from either party, except in the event of a violation of any terms or defaults of any payments or responsibilities due under this Lease, which are governed by the terms in Paragraph 11 of this Lease.
15. Tenant agrees that if any legal action is necessary to recover the property, collect any amounts due under this Lease, or correct a violation of any term of the Lease, Tenant shall be responsible for all costs incurred by Landlord in connection with such action, including any reasonable attorney's fees.
16. As required by law, the Landlord makes the following statement: "Radon gas is a naturally-occurring radioactive gas that, when accumulated in sufficient quantities in a building, may present health risks to persons exposed to it. Levels of radon gas that exceed federal and state guidelines have been found in buildings in this state. Additional information regarding radon gas and radon gas testing may be obtained from your county health department."
17. The following are additional terms of this Lease: **N/A**
18. The parties agree that this Lease, including the following attachments: **none attached**

Is the entire agreement between them and that no terms of the Lease may be changed except by written agreement of both parties. This Lease is intended to comply with any and all applicable laws relating to landlord and tenant relationships in this state. This Lease binds and benefits both the Landlord and Tenant and any heirs, successors, representatives, or assigns. This Lease is governed by the laws of the state of Tennessee.



Signature of Landlord

Rock A Wooster

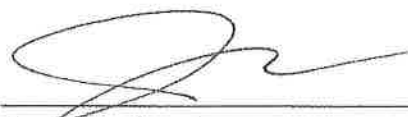
Name of Landlord



Signature of Landlord

Spinal Health Care Associates P.C.

Name of Tenant



Signature of Landlord

Jason D Coleman

Name of Landlord

Dr. Robert C. Gordon

4002 Streamlet Way
Monroe, NC 28110
(704) 698-0461

Education

- | | |
|-----------|---|
| 1964-1966 | A.A. Degree – Education
Miami-Dade Community College- Miami, FL |
| 1966-1968 | B.S. Degree – Physical Education; Recreation and Sports Science
Florida State University – Tallahassee, FL |
| 1972-1975 | B.S. Degree – Biological Science
Doctor of Chiropractic Degree
National College of Chiropractic |

Postgraduate Education

D.A.A.P.M. – Diplomate, Board Certification, Pain Management;
American Academy of Pain Management
Certified in the Rating of Physical Impairment (NCC)
Certified in Orthopedics of the Cervical Spine (LACC)
Certified in Orthopedics of the Lumbo-Sacral Spine (LACC)
Certified in Acupuncture (NCC)
Certified in MUA (TCC and Parker)
Board Certified in MUA, Royal College of Chiropractic Medicine (RCPS US) 2001
Diplomate, National Board of Chiropractic Examiners
U.S. Department of Labor – OTI 501 General Industry
Masters postgraduate studies – Exercise physiology – FSU
160 hours leading to diplomate status in Chiropractic Orthopedics
12 hours in Applied Spinal Disability Evaluation
120 hours in Industrial Chiropractic Consulting – Northwestern
College of Chiropractic
OTI 501 – OSHA Outreach Training Georgia Tech. Program
General Industry (U.S. Dept. of Labor)
OTI 225 – Applied Ergonomics and Workplace Disorders

Teaching Experience

Dade County Public Schools (Physical Education & General Science) – four years
North Miami High School adult education (Nutrition and Exercise) – two years
Broward Community College adult education (Nutrition and Exercise) – two years
Water Safety Instructor – American Red Cross – six years
CPR American Heart Association – Dade County- six years
Instructor Sports Medicine, Athletic training – National College of Chiropractic
(extracurricular)

Postgraduate Faculty

Parker College of Chiropractic (MUA 1991-93)
Cornerstone Professional Education, Inc. (1993-present)
MUA for CME credits hospital credentialed (1992-93)
National College of Chiropractic (MUA 1994-present; Industrial Program 1997-present)

Professional Licenses

State of Florida CH002444
State of New Jersey 38MC00629200

Professional

Private practice in south FL (1975-96) – Industrial; Sports; PI; MUA; and Scoliosis
President, Cornerstone Professional Education, Inc. (1988-present)
Seminar Production; Professional Education; Hospital and Ambulatory Surgical
Center MUA Program consulting; individual doctor consulting in the fields of MUA,
Safety and Industry, and Applied Ergonomics in the Workplace

Professional Appointments

Immediate Past President, National Academy of MUA Physicians
Executive Director, National Academy of MUA Physicians
Postgraduate Fellowship, Low Back Dysfunction, Harvard Medical School, June 1991
Examining doctor, Florida Board of Chiropractic (1989-95)
Expert Witness, Peer Review, Agency for Health Care Administration, Florida Board of
Chiropractic (1993-2000)
Resident and Director of Chiropractic Services, Parkway Regional MUA Center
(1992-93)
Vice Chairman, National Academy of MUA Physicians (1995-97)
Peer Review, North American Pain and Disability Group (1995-97)
Peer Review, CRA (1992-95)

MUA Consultant: Monsour Medical Center, Jeanette, PA; Edgewater Medical Center, Chicago, IL; Center For Special Surgery, Hawthorne, NJ; Center For Advanced Surgery, Paramus, NJ; Orthopedics of Lancaster, Lancaster, PA; Montclair Medical Center, Montclair, NJ; Northern Hospital of Surry County, Mt Airy, NC; DeQuincy Memorial Hospital, DeQuincy, LA; Gulf Pines Hospital, Port St. Lucie, FL; Newport News General Hospital, Newport News, VA; Parkway Regional Medical Center, N. Miami Beach, FL; and Venture Ambulatory Surgical Center, N. Miami Beach, FL.; North Jersey Center For Surgery, Newton, NJ.; Central Jersey Surgery Center, Eatontown, NJ; Market Street Surgery Center, Saddle Brook, NJ; Center For Surgery at Millburn, Millburn, NJ; Sheehan Memorial Hospital (Buffalo, NY); Twin Rivers Surgery Center, Phillipsburg, NJ; The Surgery Center at Cedar Knolls, NJ; Clay Surg. Center, Jacksonville, FL; President, MUA of TN.

Published Work

- "Exercise and the young child", Journal of Clinical Chiropractic, 1974
"Justifying MUA within the scope of chiropractic", FCA Journal, Nov.-Dec. 1995
Numerous articles for the FCA Journal on Scoliosis, 1987-89
Copyright syllabus: MUA course taught by Cornerstone Professional Education, Inc.; sponsored by National University of Health Sciences (1992,1994,1997,1998).
Co-author of the national standards and protocols for the National Academy of MUA Physicians
Author/Editor of: "Manipulation Under Anesthesia; Concepts In Theory and Application". (Published April 2005 -CRC Press/Taylor and Francis)
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"Quantification and Credibility in the Health Care Arena", *Dynamic Chiropractic Journal*, July 30, 2001. Pg. 10-11.
"Manipulation Under Anesthesia: What Constitutes Credibility?", *Dynamic Chiropractic Journal*, January 15, 2001

Personal and Professional Awards and Achievements

Eagle Award, Boy Scouts of America (received at age 13)
Phi Epsilon Kappa – Physical Education Honorary Fraternity (1967)
Sigma Delta Psi – Athletic Honorary (1967)
Life Member, Optimist Internationale
Chiropractor of the Year – Broward County FL (1984-85)
Kudo Award for Outstanding Professional Achievement – FCA 1988

Community and Professional Involvement

Former Secretary Miramar/Pembroke Chamber of Commerce (1980-81)
Ambassador, Miramar/Pembroke Chamber of Commerce (1982)
Co-chairman First Annual Physical and Visually Impaired Track and Field Meet
sponsored by the Miramar Optimist Club (1983-84)
Chamber representative to the Broward Industrial Council of Broward County
Employment and Training Administration (1984)
Judging qualified for the State Body Building Association, state of Florida (1982)
Member of: American Chiropractic Association (1975-82)
Florida Chiropractic Association (1977-present)
(State chairman scoliosis committee, 1987-90)
Broward County Chiropractic Society
President (1987-88)
Past President (1988-89)
Co-chairman insurance relations committee
Numerous offices held including program chairman and director
North Carolina Chiropractic Association (2000-present)
International Academy of Chiropractic Industrial Consultants
Chiropractic Rehabilitation Association (1989)
American College of Sports Medicine
International consultant of backschool – South Florida State Hospital
(1988)
Fellow, American Back Society – Industrial Consultants Committee (1989)
National Academy of MUA Physicians (Charter)
Appointed to the Advisory Committee For Health Occupations – Broward County School
System (1987-88)
Appointed to the School System Advisory Committee, Broward County Public Health
Unit (1987-92)
Appointed to the Ad Hoc Committee for the Medical Services Magnet Program, Broward
County School System (1990-94)
Chiropractic Provider for the Broward School System (1988-95)

Robert C. Gordon, D.C., FABCS, FRCCM, DAAPM

CASE REPORTS



Use of Cervical Spine Manipulation Under Anesthesia for Management of Cervical Disk Herniation, Cervical Radiculopathy, and Associated Cervicogenic Headache Syndrome

James Herzog, DC^a

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ABSTRACT

Objective: To demonstrate the benefits of cervical spine manipulation with the patient under anesthesia as an approach to treating a patient with chronic cervical disk herniation, associated cervical radiculopathy, and cervicogenic headache syndrome.

Clinical Features: The patient had neck pain with radiating paresthesia into the right upper extremity and incapacitating headaches and had no response to 6 months of conservative therapy. Treatment included spinal manipulative therapy, physical therapy, anti-inflammatory medication, and acupuncture. Magnetic resonance imaging, electromyography, and somatosensory evoked potential examination all revealed positive diagnostic findings.

Intervention and Outcome: Treatment included 3 successive days of cervical spine manipulation with the patient under anes-



thetia. The patient had immediate relief after the first procedure. Her neck and arm pain were reported to be 50% better after the first trial, and her headaches were better by 80% after the third trial. Four months after the last procedure the patient reported a 95% improvement in her overall condition.

Conclusion: Cervical spine manipulation with the patient under anesthesia has a place in the chiropractic arena. It is a useful tool for treating chronic discopathic disease complicated by cervical radiculopathy and cervicogenic headache syndrome.

The beneficial results of this procedure are contingent on careful patient selection and proper training of qualified chiropractic physicians. (*J Manipulative Physiol Ther* 1999;22:166-70)

Key Indexing Terms: Chiropractic Manipulation; Anesthesia; Intervertebral Disk Herniation; Cervical Vertebra

INTRODUCTION

Spinal manipulation under anesthesia (MUA) has been used to treat a wide variety of musculoskeletal disorders dating as far back as the 1930s and 1940s. Most of the forms of MUA discussed in the literature have been performed and documented by the medical and osteopathic professions.^{1,2} It would also appear that most of this research has dealt primarily with MUA as an approach to treating certain types of mechanical lumbar and cervical spine dysfunction. The generally accepted rationale for how MUA works is based on solid scientific data relating to muscle and joint physiology. Authors and researchers such as Guyton,³ Fung,⁴ Crowe,⁵ and Hill⁶ have all helped to establish the unique physiologic properties that synovial joints and muscles have and how those properties act when subjected to traction and stretching forces. MUA in the clinical setting is based on the hypothesis that fibrous adhesions in the joint capsules and surrounding supportive tissues can be altered by the use of specific manipulative and stretching techniques. The result of altering adhesions is increased mobility of the motor unit caused by an increase in flexibility of the supportive

tissues.⁷⁻¹⁰ Siehl¹¹ and Claybourne¹² have documented the validity of MUA as a procedure useful in treating musculoskeletal disorders when restriction of the joint, joint capsule, and surrounding musculature has taken place as a result of the formation of fibrous adhesions.

Over the past 15 years, new medical and chiropractic research has documented the benefits of SMT for certain types of musculoskeletal disorders. Prestigious medical journals such as *Spine*, *British Journal of Industrial Medicine*, *New England Journal of Medicine*, *Annals of Internal Medicine*, *Journal of the American Medical Association*, and *Journal of the American Osteopathic Association*¹³⁻¹⁸ have all documented these benefits. This research explosion comes at an interesting time for our profession. Clearly, as time has been going on members of the osteopathic profession have been gradually decreasing their use of SMT while increasing their use of pharmacology and surgery to treat patients. Remarkably, this has been occurring at the same time that much of the research and excitement about the benefits of SMT has been taking place. This leaves most spinal manipulation performed by the chiropractic profession.

Spinal manipulation has been shown to be an effective treatment for certain types of spinal conditions. Spinal MUA however, may provide therapeutic benefits to those who have been unresponsive to the traditional manipulative approach. This article discusses the use and benefits of spinal MUA in a case of cervical disk herniation and associated cervical radiculopathy and cervicogenic headache syndrome.

^aPrivate practice of chiropractic orthopedics, Freehold, New Jersey. Submit reprint requests to: James Herzog, DC, The Back and Neck Center, 70 Schanck Rd, Freehold, NJ 07728.

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CASE REPORT

A 29-year-old woman in excellent health was involved in a rear-end collision in which the car she was driving was hit from behind while at a stoplight. She was wearing a shoulder harness seatbelt; however, she recalled being thrown backward on impact and then forward, as in the classic whiplash scenario. She denied any head trauma or loss of consciousness. She complained of dizziness and nausea at the scene of the accident and was taken by ambulance to a local hospital where she was examined and underwent a series of cervical spine radiographs. All radiographs were negative for fracture. The patient was then given muscle relaxants and pain medication and was released. Over the next several days, she began to have neck and lower back pain. Within a week she complained of numbness and tingling that radiated into the right arm and hand. The patient consulted a local chiropractor who diagnosed cervical and lumbar sprain. He treated her for approximately 3.5 months. Treatment included spinal manipulation and electric muscle stimulation. No improvement was noted, and by now the patient had begun to have severe headaches at an increasing frequency. She then consulted a local orthopedist who ordered lumbar spine radiographs. These were negative for fracture or gross osseous pathologic conditions. Physical therapy was ordered for 8 weeks. Muscle relaxants and anti-inflammatory medication were also prescribed. At the end of the 8 weeks, she felt worse. She now had constant severe neck and back pain. Her right arm tingled daily, and she had daily headaches as well. The patient also complained of increased episodes of dizziness and nausea. She was unable to perform her tasks at work as a secretary and was placed on disability by her orthopedist. She was then referred to a neurologist who ordered cervical and lumbar spine magnetic resonance imaging studies. The cervical spine studies demonstrated a right posterior C5/C6 disk herniation with no apparent spinal or foraminal stenosis and normal spinal cord morphology and signal. The lumbar spine studies demonstrated a mild levoscoliosis and possible conjoined nerve roots on the left at the L4/L5 level. No spinal or foraminal stenosis was noted and no disk herniations were present. Electromyographic examination of the upper and lower extremities was ordered by the neurologist. The result of the cervical study was a C5/C6 radiculopathy. The lumbar study was normal with no signs of radiculopathy. A somatosensory evoked potential study was ordered on the upper extremities and was suggestive of somatosensory dysfunction on the right side. The result of a magnetic resonance imaging study of the brain was normal. The neurologist referred the patient back to her orthopedist, where several more weeks of physical therapy were ordered. After this course of treatment, she was still in severe pain. Her orthopedist offered her little else and suggested she consult a neurosurgeon.

The patient was hesitant to do so. After some discussion, her orthopedist recommended that she try chiropractic treatment again and referred her to my office. At the initial consultation, the patient complained of stabbing neck and upper back pain that radiated into the right scapula. She had numb-

ness and tingling radiating down her right arm into her hand. She stated that her headaches were severe and complained of nausea and dizziness. She described having difficulty with her concentration and attention since her accident. She thought she was forgetful and complained of having difficulty getting a good night's sleep because of her pain. Her lower back was painful but not as severe as the neck pain. No lower extremity paresthesias were noted, and bowel and bladder function was normal. On evaluation, the upper and lower extremity reflexes appeared to be normal at +2 on the right and left.

Palpation revealed trigger points and muscle spasms of the trapezius, scalenes, suboccipital muscles, and rhomboid muscles bilaterally in the cervical and thoracic spines, as well as tenderness over the lumbar extensor musculature at the L3/L4/L5 levels. The mid to lower trapezius muscles had many localized areas of hypertonic muscle fibers that reproduced cervical and occipital pain on digital pressure.

Flexion in her cervical spine was painful at 60 degrees, whereas extension produced pain and restriction at 35 degrees. Right and left rotation were full and pain free, whereas right and left lateral flexion produced pain and restriction at 25 degrees. Muscle strength in the upper extremities was normal at 5/5. Grip strength was 5/5 and symmetric. Peripheral sensation testing of the upper extremities demonstrated hypoesthesia in the right C5 and C6 dermatomal levels.

The cervical foraminal compression test was positive on the right for radicular pain. This maneuver, when performed on the left side, also produced local neck pain on the left, indicating facet jamming. The Soto Hall test was positive for cervical and upper thoracic spine pain, and spinous percussion produced pain at the C2/C3 and C5-T3 levels. A right shoulder depression test alleviated the cervical and arm pain, whereas the left shoulder depression test increased the pain. George's test for potential vertebral artery syndrome was negative on the right and left sides. Valsalva maneuver was negative for radicular pain but did elicit neck pain.

Evaluation of her lumbar spine revealed all ranges of motion to be full. There was pain noted on extension and on bilateral rotation. Evaluation of the lower extremity muscle strength was 5/5. Toe to heel walk was normal. Straight leg raising did not cause any radiating pain. Hibbs test was negative bilaterally for sacroiliac joint involvement. Kemp's test elicited low back pain without radiculopathy, suggesting of a facet syndrome. My impression was cervical disk herniation at the C5/C6 level with a C5/C6 cervical radiculopathy, lumbar sprain, lumbar facet syndrome, cervicothoracic fibromyalgia, and cervicogenic headache syndrome, all posttraumatic and chronic.

The patient was asked to fill out a visual analog pain intensity scale to describe her cervical spine pain. A 0 to 10 numeric scale was used, with 0 representing "no pain" and 10 representing "the worst possible pain." The patient rated her pain as an 8. I recommended treatment for 6 weeks at a frequency of 3 times per week. Treatment included specific spinal manipulation to the cervical, thoracic, and lumbar

spines, as well as ultrasound therapy and spray-and-stretch therapy. She agreed and was reevaluated 6 weeks later. On the reevaluation, she was still in obvious distress. Her lumbar spine pain had resolved; however, she continued to have paresthesias into her right hand and was still complaining of headaches, although somewhat less severe. She now rated her pain as a 7 on the pain scale. I explained to the patient that her chronic pain was not responding as quickly as I had hoped.

We discussed MUA as a possible treatment option. This patient was a candidate for the procedure on the basis of specific criteria that have been accepted and taught by schools such as National College of Chiropractic and Parker College of Chiropractic.^{19,20} The patient agreed to the 3-day procedure. She underwent preadmission testing with an anesthesiologist and was medically cleared for the procedures. MUA on the patient's cervical and thoracic spines was performed on 3 successive days. The patient was asked to fill out the pain intensity scale after the 3-day procedure. She rated her overall pain between 3 and 4. Follow-up treatment consisted of 6 weeks of post-MUA therapy. This included spinal traction, spinal manipulation, hot packs, interferential stimulation, and stretching techniques to the affected regions of the spine. The patient was released 6 weeks later, when she reported 90% improvement of her neck and upper back pain, no upper extremity paresthesias, and an improvement in her headaches, which she estimated to be 95% better. Her pain scale rating was a 2. She returned to work and had maintained the improvement 3 months later.

DISCUSSION

In the past the medical profession has generally taken the approach to treating cases of cervical disk herniation with medication, physical therapy, epidural steroid injections, and ultimately surgery. The chiropractic profession offers these patients manipulation and rehabilitative measures. MUA is an old procedure now reawakening in our profession. The generally accepted indications and contraindications for this procedure include the following.

Indications

1. Bulging, protruded, prolapsed, or herniated disks without free fragment that are not suitable for surgery
2. Frozen or fixated articulations from adhesion formation
3. Failed low back surgery
4. Compression syndromes, with or without radiculopathies, caused by adhesion formation but not associated with osteophyte formation
5. Restricted motion that causes pain or patient apprehension, but manipulation is the therapy of choice
6. Patient who is slow to respond to manipulation and adjustments when manipulation is the treatment of choice
7. Patient who has unresponsive pain that interferes with the function of daily life and sleep patterns but that falls within the parameters of manipulative treatment
8. Unresponsive muscle contracture that is preventing normal daily activities and function

9. Posttraumatic syndrome injuries from acceleration-deceleration mechanisms that result in painful exacerbations of chronic fixations
10. Chronic recurrent neuromusculoskeletal dysfunction syndromes that are easily exacerbated
11. Neuromusculoskeletal conditions that are not suitable for surgery but have reached MMI with conservative therapies
12. Patients who are considered disk surgery candidates who fall within the parameters of MUA, which may be an alternative or interim step and may be useful as either a therapeutic or diagnostic tool in determining the prognosis of the patient's care

Contraindications

1. Any form of malignancy
2. Metastatic bone disease
3. Tuberculosis of the bone
4. Acute bone fractures
5. Manipulation to old compression fractures
6. Acute inflammatory arthritis
7. Acute inflammatory gout
8. Uncontrolled diabetic neuropathy
9. Syphilitic articular or periarticular lesions
10. Gonorrheal spinal arthritis
11. Advanced osteoporosis
12. Spinal cord tumor
13. Disk herniation protruding 5 mm or more into spinal canal
14. Widespread staphylococcal or streptococcal infection
15. Presence of an aortic aneurysm
16. Unstable spondylosis
17. Any medical problem in which anesthesia is contraindicated¹⁹

Certain conditions, most of which are typically seen in the chiropractic setting, that have been shown to respond favorably to MUA are documented in the literature and include chronic noninflammatory arthritis, fibrositis, myofascial herniated disk syndrome, joint fixation syndromes, a failed back surgery syndrome.^{19,21-23}

It is important for the patient's condition to fall into the criteria previously listed if MUA is to be considered. It is of equal importance that the physician be properly trained in the techniques of MUA because they differ from those used in the office setting. MUA procedure and protocols begin with informed consent. Explanation of the medical, surgical and procedural options available to the patient are adequately covered before the procedure. The patient is draped appropriately, gowned and is accompanied to the operating area. Appropriate monitoring instruments are placed on the patient. These typically include a blood pressure cuff, heart rate monitor, and pulse oximeter. Oxygen is also supplied by the anesthesiologist or attending nurse. When the patient and doctors are ready, the sedative is administered by the anesthesiologist.

When MUA to the cervical spine is performed, the patient is lying supine on the table. With the patient's arms crossed

over his or her chest, the approach is from the cephalad end of the table. Axial traction is applied to the cervical spine by manual means while the thorax is stabilized by the first assistant. Traction is also achieved in flexion, lateral flexion bilaterally, and in an oblique manner bilaterally. The patient's head is then rotated to the right, and a specific contact is taken on a vertebra. The spinal segment is taken into full range, the elastic barrier of resistance is reached, and a low-velocity thrust is performed. The procedure is then repeated on the opposite side of the cervical spine.

When MUA to the thoracic spine is performed, the patient is lying in the supine position on the table. The arms are crossed over the chest to achieve traction in the thoracic spine. Segmental selection is made by rolling the patient to one side. A contact is made and the patient is rolled back over. Again a low-velocity thrust is performed. This procedure can then be used on other thoracic segments.

Success of the procedure depends on the following:

1. *Careful patient selection:* The patient's condition must meet certain criteria. If this is done after the generally accepted protocols, the success of the procedure should be higher.
2. *Qualification of chiropractic physicians:* These procedures are highly specialized and require training and certification. The procedures and techniques that are currently used and accepted as standard are taught by at least 3 chiropractic institutions through their postgraduate divisions. The physician undergoes at least 36 hours of classroom training and must perform at least 3 MUA procedures under instructor observation. The physician must then pass a written examination. On successful completion of all requirements, the doctor is certified to perform these procedures.
3. *Post-MUA therapy:* This 6-week program is essential to the success of the procedure. Post-MUA care includes hot packs; passive range of motion stretching of the cervical, thoracic, and lumbar spines; and interferential currents coupled with cryotherapy. This procedure is to be administered consecutively for 2 to 3 days, depending on the chronicity of the case. After the first week, proprioceptive neuromuscular facilitation stretching, manipulation, and isometric and flexibility exercises are initiated. At the beginning of the second week of care, a progressively resistant exercise (isotonic) program in conjunction with manipulative therapy is instituted. From the third week to the end of the therapy program, active exercise continues 3 times weekly, with manipulation being performed only once weekly. This is to promote joint stabilization, patient independence, and decreased physician dependence. The post-MUA therapy continues for a total of 6 to 8 weeks. At that time the patient will have achieved a maximum therapeutic benefit and be discharged. Rehabilitation and strengthening of the supporting tissues will help maintain the effects of the alteration of the fibrous adhesions that have occurred with the MUA.
4. *The use of anesthesia:* Perhaps the major reason that this procedure works so well is because anesthesia is used. All

anesthesia is not the same. For this procedure, the anesthesia usually used is methohexital (Brevital) or propofol (Diprivan). Thiopental sodium may also be used; however, clinical experience with the use of this drug, a barbiturate, dictates that the patient wakes in a very groggy and disoriented state, will generally feel like he or she has a hangover, and may have a headache. If a patient has head or neck pain to begin with, thiopental sodium may not be the best choice. Methohexital and propofol are fast-acting sedatives, or hypnotics, because they can easily cross the blood-brain barrier.²⁴ Propofol is rapidly cleared from the blood by both distribution into fatty tissues and rapid metabolic clearance through the liver to inactive metabolites. Although the terminal elimination half-life of propofol is 1 to 3 days, the rapid metabolic clearance results in a short duration of clinical effect. The sedative effects typically dissipate within 5 to 10 minutes after the infusion is discontinued.²⁴ This is why the patient awakes feeling fresh and is fully alert usually within 1 hour.

These anesthetics place the patient in a twilight state. This is not deep sedation as is seen in open-body surgery. The patient is in a relaxed sleep, and the muscle spasm and splinting reflexes are depressed. This is because methohexital and propofol help to inhibit the internuncial neuron transmission to the alpha motor neurons to prevent the body's secondary response of protective muscle spasm when pain is felt, usually from type II and type IV mechanoreceptor sources at the joint articulation site or from pain-sensitive tissue in muscles.²⁵⁻²⁸ With no muscle spasm present and with the patient anesthetized, the adhesions in the muscles can be stretched and altered. This elongation of the muscle allows the physician to take the joint to its full range of motion, when a low-velocity thrust is used to further stretch and alter the adhesions in the joint and capsules. This alteration of adhesions may be, in part, responsible for the increase in spinal flexibility and the overall decrease in pain that has been reported.¹⁹ Cervical disk herniation with irritation of the surrounding nerve root and fibrotic changes in the muscles and joints has been shown to be responsive to MUA. The work of Gordon and Russo,¹⁹ Greenman,²³ and Hughes²² seems to corroborate this finding. Prior work by Alexander,²¹ Nelson et al,²⁹ and Ben-David and Raboy³⁰ have all documented the benefits of MUA on lumbar disk syndromes and associated fibrotic changes in the lumbar spine. Although the exact mechanism of this therapeutic approach is still hypothesized, knowledge of muscle and joint physiology likely holds the secret. More research is necessary for proof that adhesion alteration or breakdown actually occurs. Regardless, it seems to appear that MUA has a positive effect on certain types of conditions that have been unresponsive to traditional therapeutic approaches.

My patient demonstrated an increase in her cervical and thoracic ranges of motion shortly after the first procedure. With each successive day of the MUA, this patient continued to display increases in spinal range of motion and increases in supporting muscle flexibility. Her complaints gradually decreased, and she was found to have maintained

the benefits of increased range of motion and decreased pain almost 4 months later.

This article discusses a case in which spinal MUA was used on a patient who had not made substantial improvement with traditional conservative treatment. Significant increase in overall muscle flexibility and spinal range of motion was realized after each procedure. The rationale for MUA use is to control and alter the fibrous adhesions that are a result of the inflammatory cycle. By altering adhesions that are responsible for restricted muscle and joint flexibility, we are able to restore muscle and joint integrity. This is helped by the use of anesthesia, whereby muscle spasm and splinting reflexes are lost but ligamentous and pain reflexes are maintained.

CONCLUSION

MUA has been shown to be of benefit in a case of cervical disk herniation with cervical radiculopathy and cervicogenic headache syndrome. At present, the literature suggests that certain types of conditions respond favorably to MUA. Most of this research surrounds conditions typically seen in the chiropractic setting. Discopathic disease and adhesive muscular disorders may benefit from this approach when other modalities have failed. Spinal MUA may be a promising tool that chiropractors can call on when presented with patients whose conditions fit certain criteria. Proper patient selection, physician training, and careful follow-up therapy are all important aspects of MUA. More research needs to be done to prove or disprove the theory behind adhesion alteration. Until then, case reports will continue to be the only measurable tool used to document MUA procedures and their effects.

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Manipulation with the patient under anesthesia

PHILIP E. GREENMAN, DO

Manipulation while the patient is under anesthesia is an old, widely recognized procedure in musculoskeletal medicine. It is used for treating acute and chronic musculoskeletal conditions with significant biomechanical dysfunction unresponsive to conservative therapy. The procedure is helpful when muscle spasm and irritability preclude success without anesthetization of the patient. Safety and effectiveness are favored by appropriate selection of patients, knowledge of indications and contraindications, suitable anesthetic, and services of a qualified physician trained in structural diagnosis and manipulative technique. A team approach is recommended. To illustrate effective use of the procedure, a classic case is described.

(Key words: Manipulation, back pain, anesthesia, manual medicine)

Mobilization of the musculoskeletal system with the patient under anesthesia has been part of the armamentarium of manual medicine for more than 60 years. This procedure has been applied to the spine, particularly in the lumbosacral and cervical regions, as well as peripheral joints. With the development of manual medicine procedures that use intrinsic activating forces and inherent mobility, the

need to perform mobilization with impulse (that is, high-velocity, low-amplitude thrust technique) with the patient under anesthesia has been less frequent.

Manipulation while the patient is under anesthesia should be performed for specific indications in a patient who has been evaluated adequately. Appropriate concern must be given to contraindications, skill of the anesthesiologist, and the competence of the manipulating physician. The following case illustrates the appropriate use of this procedure.

Report of case

A 28-year-old woman was first seen in consultation 4 days after admission for a chief complaint of painful stiffness of the cervical spine, intractable nausea, and multiple episodes of vomiting for the preceding 5 days. Initial hospital care had consisted of intravenous hydration and pain control with diazepam (Valium), 5 mg to 10 mg every 4 hours; hydrochloride meperidine (Demerol), 50 mg every 4 hours as needed for pain; and promethazine hydrochloride (Phenergan) as needed for control of nausea. The complaint had begun 4 weeks before admission when the patient experienced acute neck pain after an incident in which, while lying in the prone position, she lifted her head from the left rotated position and turned suddenly to the right. Onset of pain, stiffness, and muscle spasm was immediate. The pain was located to the right upper cervical and midcervical area with radiation to the right scapular and upper thoracic region and to the posterior aspect of the upper arm. Initial studies included x-ray films of the cervical spine

Dr Greenman is professor, Department of Biomechanics, Michigan State University, College of Osteopathic Medicine, East Lansing, Mich.

Reprint requests to Philip E. Greenman, DO, Department of Biomechanics, Michigan State University, College of Osteopathic Medicine, East Lansing, MI 48824-1316.

and cervical myelography, the results of which were reported to be normal. Magnetic resonance images of the cervical spine 3 days before admission also were interpreted as showing no abnormality. Conservative care, including cervical traction and physical therapy modalities, had been ineffective.

Physical examination revealed considerable restriction of cervical motion, both active and passive ranges, in the directions of extension, right sidebending, and right rotation. Moderately severe deep muscle spasm overlay the right posterior cervical region, particularly C4-C6. Segmental mobility was restricted at C4, C5, and C6 in the directions of backward bending, right sidebending, and right rotation. Respiratory mobility of the right upper rib cage was restricted with tenderness at the rib angles on the right side at T2, T3, and T4 with palpable spasticity of the iliocostal insertions. All deep tendon reflexes were intact. There was no significant sensory loss. No motor weakness was present except for loss of effort of right shoulder elevation because of pain.

Additional conservative care was given, including manual medicine of the functional (balance and hold) and muscle-energy type and trigger-point injection in the regions of muscle irritability. Despite all conservative measures, however, the patient's condition was nonresponsive.

Further evaluation was made by dynamic flexion extension studies of the cervical spine in the lateral projection. This study revealed marked restriction of motion in both flexion and extension of C3, C4, C5, and C6.

At surgery, with the patient under general anesthesia, mobilization with impulse was provided to the thoracic spine and right rib cage for the restoration of neutral mechanics. The cervical spine was mobilized with impulse segment by segment on both the right and left side. The patient tolerated the procedure well. The patient was discharged 24 hours later with greatly improved cervical mobility and reduction in pain with no further nausea or vomiting. She was treated for 2 weeks with progressive, increasing-resistance physical therapy exercises, and with manual medicine of the muscle-energy type.

The patient was symptom-free for the succeeding 18 months, when she was seen again for mild, recurrent, painful cervical stiffness to right rotation. Minimal restriction was found in C4, C5, and C6 on the right in a pattern similar to that seen originally. This problem responded completely to a 10-day course of manual medicine of the muscle-energy type. She is currently symptom-free.

Discussion

This case demonstrates the role of mobilization with the patient under anesthesia. This patient sustained an acute episode of dysfunction of the cervical spine resulting in considerable disability. Other organic causes for her symptom complex were excluded by comprehensive evaluation. She was unresponsive to multiple forms of conservative therapy including manual medicine procedures that involved inherent force and intrinsic activating force. The patient's condition was greatly improved 24 hours after undergoing manipulation under anesthesia, and she was symptom-free within 10 days. No subsequent sequelae occurred for 18 months. Minor recurrence then responded quickly to more usual forms of manual medicine.

Criteria

Physicians have extensively used manipulation with the patient under anesthesia for the treatment of acute and chronic musculoskeletal conditions with evidence of biomechanical dysfunction as a significant component. It has been found useful in patients with acute and chronic muscle spasm, shortening, and contracture. The procedure requires appropriate patient selection, knowledge of indications and contraindications, appropriate general anesthesia, and the services of a well-qualified physician trained in structural diagnosis and manual medicine technique.

Indications

Manipulation with the patient under anesthesia is useful in chronic vertebral somatic dysfunction unresponsive to conservative management. The procedure is also helpful in acute vertebral dysfunction that cannot be controlled

(continued on page 1167)

by conservative means, with muscle spasm and irritability that preclude success with manual medicine procedures without anesthesia. Chronic myofibrositis of a nonrheumatic nature^{1,2} that has been nonresponsive to conservative care is also aided by this procedure. Manipulation with the patient under anesthesia can be used to enhance recovery from a wide variety of acute and chronic functional musculoskeletal disorders.

Perhaps the greatest indication for this procedure is the inability of a skilled manual medicine practitioner to achieve maximal function of the dysfunctional regions by other forms of manual medicine. The need for manipulation with the patient under anesthesia is not common. Morey³ reported that only 3% of hospitalized patients with musculoskeletal disorders in a 3-year period required this procedure.

Contraindications

Contraindications can be viewed as absolute and relative. Most authors agree that absolute contraindications include joint hypermobility or instability. Malignant disease, either primary or secondary, of the spinal cord or vertebral column also precludes this procedure.⁴ Acute inflammatory joint disease and bone or joint infection are further contraindications. Obviously, no patient with a fracture of the vertebral column should undergo manipulation while under anesthesia. Organic neuropathies, particularly those associated with diabetes, should also preclude use of this procedure.

Relative contraindications are osteoporosis, in which considerable care in the procedure must be recognized, as well as herniation of the nucleus pulposus of an intervertebral disk, particularly with an extruded free fragment. Some authors report some improvement in the presence of known intervertebral disk disease, but this has been shown to be temporary in nature.⁵⁻⁸

Preoperative evaluation

A comprehensive history and physical examination is required with particular attention to ruling out any potential contraindication and to identify the significant somatic dysfunction

pattern that has been nonresponsive to other manual medicine procedures. Laboratory evaluation should be sufficient to rule out contraindications and assure the ability of the patient to undergo general anesthesia. X-ray examination of all the spinal regions to be manipulated is necessary, not only to rule out organic disease and other contraindications, but also to demonstrate the anatomic features present. Dynamic studies of flexion and extension in the lateral projection as well as lateral bending x-ray films in the anteroposterior projection are useful in confirming the regions and directions of motion restriction. Many authors^{2,9} also strongly advocate the inclusion of anteroposterior and lateral projections of the lumbar spine with the patient in the erect position for postural study. If significant short leg and pelvic obliquity with sacral base unleveling are identified, the use of lift therapy may be considered.

Type of anesthesia

The purpose of the anesthesia is to obliterate the pain and muscle spasm that has prevented other forms of conservative manual medicine care from being effective. Some authors have used caudal analgesia,^{10,11} whereas most others have recommended general anesthesia.^{1,3,5,12-15} One benefit of a regional procedure, such as caudal analgesia, is that the patient remains awake and can be cooperative, while the muscle spasm is obliterated and the pain is relieved. Most often, general anesthesia is required, particularly in regions other than the lumbar spine. It must be emphasized that administration of general anesthesia is a hospital procedure only and should be performed by a competent anesthesiologist.

Operative procedure

Manipulation with the patient under anesthesia usually includes mobilization by direct action with and without impulse in the areas of motion loss. Mobilization without impulse of the articular type is frequently sufficient in the absence of significant capsular and pericapsular adhesions. Mobilization with impulse (high-velocity, low-amplitude thrust technique) is frequently necessary, particularly in

Table 1
Special Considerations for Use of
Manipulative Treatment
With Patient Under Anesthesia:
Cervical Spine

Indications

- Acute or chronic cervical, cervicobrachial, and cervicocranial syndromes nonresponsive to conservative management
- Somatic dysfunction considered to be a significant component in the foregoing syndromes

Contraindications

Absolute

- Hypermobility/instability
- Evidence of myelopathy (long tract spinal cord signs)
- Rheumatoid arthritis
- Down's syndrome

Relative

- Upper extremity neurologic deficit
- Carotid and/or vertebral artery disease (atresia or atherosclerosis)
- Advanced spondylosis and spondylarthrosis

Preoperative evaluation

- X-ray studies of cervical spine including flexion/extension lateral, open mouth, anteroposterior, and both oblique projections
- Complete neurologic-physical examination
- Evaluation for carotid bruit with supplemental radiographic or sonographic evaluation if indicated
- Supplemental imaging studies (computed tomography, magnetic resonance imaging, myelography, or diskography) if indicated by history and physical examination
- Electrodiagnostic studies if indicated by history and physical examination

Operative procedure and physician qualification

- Articulatory and high-velocity thrust techniques that do not compromise vertebral artery system, with particular avoidance of extensive rotation and extension in combination
- Physician competence in techniques just described

Table 2
Special Considerations for
Manipulative Treatment
With Patient Under Anesthesia:
Lumbar Spine and Pelvis

Indications

- Acute and chronic lumbar, pelvic, or lower extremity musculoskeletal syndromes nonresponsive to conservative management
- Somatic dysfunction considered to be a significant component of such syndromes
- Lumbar disk syndrome without evidence of acute neurologic deficit, nonresponsive to conservative care

Contraindications

Absolute

- Hypermobility/instability
- Unstable spondylolisthesis

Relative

- Herniated nucleus pulposus with extruded free fragment
- Advanced spondylosis and spondylarthrosis
- Progressive neurologic deficit of lower extremity

Preoperative evaluation

- X-ray films of lumbar spine and pelvis including anteroposterior, lateral, and both oblique projections, supplemented by flexion/extension lateral and sidebending anteroposterior motion studies
- Supplemental imaging studies (computed tomography, magnetic resonance imaging, myelography, or diskography) as indicated by history and physical examination
- Complete neurologic physical examination
- Electrodiagnostic studies (electromyography and nerve conduction) as indicated by history and physical examination

Operative procedure and physician qualification

- Articulatory and high-velocity thrust techniques that do not pull unnecessary rotary torque through segments of the lumbar spine
- Physician competence for techniques just described

cases with chronic changes. Techniques include one- and two-person lateral recumbent and Sims position procedures^{5,11} for mobilization in both neutral and non-neutral mechanics. Long axis extension techniques^{14,15} are frequently useful in the pelvic girdle for pubic and sacroiliac dysfunction.

Siehl,¹ Mensor,⁶ and Clybourne¹² also recommend maximal straight-leg raising and trunk flexion as a component of the procedure, especially to stretch out adhesive soft tissue. The operative procedure should be planned carefully so that the significant areas of dysfunction are specifically treated and that attention is given to the total musculoskeletal system. The preoperative structural examination is critical for this purpose.

Complications

Temporary flare-up of symptoms after this procedure has been reported by several patients.⁵ This flare-up is attributed to stretching of adhesions and mobilization of inflamed soft tissue. It is easily controlled with appropriate postoperative care. Serious complications have been rare. Poppen⁶ reported two cases of paralysis after manipulation by competent orthopedic surgeons with the patient under anesthesia. This complication occurred in a population of 400 cases of intervertebral disk disease. It appears that serious complications can be avoided by appropriate patient selection, suitable operative technique by a competent practitioner, and consideration for the contraindications and potential complications.

Postoperative care

The standard postoperative protocol should include appropriate analgesics and antiinflammatory agents to treat anticipated postoperative flare-up of symptoms. Orthoses, such as cervical collars and lumbosacral belts, may be appropriate but for only short periods. The enhanced motion achieved by the procedure should be maintained by both active and passive ranges of motion with appropriate stretching and strengthening exercises as indicated.

Postoperative follow-up with manual medicine other types is usually indicated for short periods.

Physician qualifications

Because the patient no longer has natural defenses while the high-velocity procedures are being carried out, the skill of the operating physician is crucial. It has been reported that postoperative hospitalization was extended in patients treated by physicians less experienced than those physicians who had extensive experience in the procedures.³

Manipulation with the patient under anesthesia should be performed by graduate manual medicine practitioners who have high-level skill and have been trained in structural diagnosis and manipulative treatment. They should have experience in manipulation while the patient is under anesthesia, with a minimum of ten cases under supervision. Additional experience in musculoskeletal medicine, such as graduate training and certification in orthopedic surgery, rheumatology, physical medicine and rehabilitation, osteopathic manipulative medicine (philosophy and practice), and general practice, is valuable but not required.

It is strongly recommended that a team of operative manual medicine physicians be used.^{12,14,15} It takes several operators to control appropriately all aspects of the musculoskeletal system throughout the procedure. Additionally, an experienced team can accomplish the procedure more quickly and save anesthesia time. Many of the techniques recommended, including the two-person Sims technique and the long-axis distraction technique for sacroiliac dysfunction, require a minimum of two operators.

Tables 1 and 2 summarize specific considerations involved in use of manipulative treatment with the patient under anesthesia in somatic dysfunctions of the cervical and lumbar spine and pelvis.

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CASE REPORTS

MANIPULATION UNDER ANESTHESIA: A REPORT OF FOUR CASES

Edward Cremata, DC,^a Stephen Collins, DC,^b William Clauson, MD,^c
Alan B. Solinger, PhD,^d and Edward S. Roberts, DC^e

ABSTRACT

Objective: To report the results of manipulation under anesthesia (MUA) for 4 patients with chronic spinal, sacroiliac, and/or pelvic and low back pain.

Methods: The treatment group was arbitrarily selected from the chiropractor's patient base who received the MUA protocol along with a follow-up in-office articular and myofascial release program that mimics the MUA procedures. The chiropractic adjustments and articular and myofascial release procedures were performed in a chiropractic office. The MUA procedures were performed in an outpatient ambulatory surgical center. Patients with chronic pain who had not adequately responded to conservative medical and/or a reasonable trial (4 months minimum) of chiropractic adjustments, and had no contraindications to anesthesia or adjustments, were selected. The 4 patients went through 3 consecutive days of MUA followed by an 8-week protocol of the same procedures plus physiotherapy in-office without anesthesia. Data included pre- and post-MUA passive ranges of motion, changes in the visual analog scale, and neurologic and orthopedic examination findings. The patients had follow-up varying from 9 to 18 months.

Results: Increases in passive ranges of motion, decreases in the visual analog scale rating, and diminishment of subsequent visit frequency were seen in each of the patients.

Conclusion: Manipulation under anesthesia was an effective approach to restoring articular and myofascial movements for these 4 patients who did not adequately respond to either medical and/or in-office conservative chiropractic adjustments and adjunctive techniques. (*J Manipulative Physiol Ther* 2005;28:526-533)

Key Indexing Terms: Manipulation, Chiropractic; Anesthesia; Manipulation, Spinal; Spine; Sacroiliac Joint; Low Back Pain

The application of chiropractic techniques, including high-velocity low-amplitude (HVLA) chiropractic adjustments, passive stretches, and specific articular and postural kinesthetic integrations,^{1,2} combined with the use of general anesthesia or conscious sedation is generally referred to as manipulation under anesthesia (MUA).

Manipulation under anesthesia allows chiropractic adjustments to be provided to patients who could not otherwise tolerate, or do not adequately respond to, in-office manual techniques. Anesthesia is used to relieve spinal pain and muscle spasm and to reduce protective guarding that may limit the reduction and/or removal of articular or myofascial adhesions during chiropractic adjustments.³ Manipulation under anesthesia is a technique available to treat patients with neuromusculoskeletal dysfunction at a greater intensity than is available in the office setting. In 1976, Morey⁴ stated, "Before MUA is indicated ask yourself whether the patient can respond to conservative care."

Early osteopathic case studies showed significant results, but the procedure was risky because of the time the patient was under general anesthesia.⁵ In 2002, Kohlbeck and Haldeman³ summarized the history and current clinical knowledge regarding MUA documented in 49 articles. Current medications and more refined treatment approaches have allowed physicians to provide these procedures with much greater safety. In fact, two large malpractice insurers

^a Private Practice of Chiropractic, Fremont, Calif.

^b Private Practice of Chiropractic, Fremont, Calif.

^c Private Practice of Medicine, Fremont, Calif.

^d Private school, Clark Magnet HS, La Crescenta, Calif.

^e Private Practice of Chiropractic, Fremont, Calif.

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Submit requests for reprints to: Edward Cremata, DC, Fremont Chiropractic Group, 38069 Martha Ave, Suite 200, Fremont, CA 94536 (e-mail: cremata@earthlink.net).

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1. Painful and restricting muscular guarding interferes with the performance of spinal adjustments, mobilizations, and soft tissue release techniques in the acute patient.
2. Articular and myofascial dysfunctions cannot be adequately ameliorated with a reasonable trial (two-month minimum) of in-office procedures in the chronic patient.
3. A medical evaluation is performed to establish anesthesia safety clearance and to determine whether alternative medical treatment may be complimentary with or preferable to MUA.
4. The patient's daily activities must be substantially interrupted by pain and dysfunction as measured with a visual analogue scale and disability measurement instruments such as the Oswestry questionnaire.

Fig 1. Indications for MUA.

for chiropractors, National Chiropractic Mutual Insurance Company (NCMIC) and Pi Omega Delta, cover MUA practitioners without any additional premium.

Manipulation under anesthesia procedures in the clinical setting are based on the hypothesis that adhesions in the joint capsules and surrounding supportive tissues can be altered by the use of specific chiropractic adjustments and stretching techniques.⁶ The increased flexibility of the supportive tissues increases the mobility of the motion segment and associated articulations.⁶ Additional suspected mechanisms for the increased motion ranges seen after MUA include the resetting of the Golgi tendon apparatus resting length.

In our experience, a large number of patients exhibit mechanical dysfunctions and persistent myofascial and/or articular motion restrictions, with many unable to perform their usual tasks at work or participate in their normal home and recreational duties. It is the opinion of Francis⁷ that approximately 3% to 10% of chiropractic patients may be candidates for these procedures. The purpose of this paper is to present how 4 patients with chronic spinal, sacroiliac, and/or pelvic and low back pain responded to MUA.

METHODS

Indications

In addition to evaluating whether intravenous (IV) anesthetic can be delivered safely, the indications for this procedure are used as illustrated in Fig 1.² The MUA procedures may be medically necessary when painful and restricting muscular guarding interferes with the performance of manipulative procedures, mobilizations, and soft tissue release techniques in the patient with acute pain or

when fibrosis-maintained articular and myofascial adhesions cannot be adequately released with a reasonable trial of in-office procedures in the patient with chronic pain. Manipulation under anesthesia has been used successfully in treating those patients unresponsive to acute and chronic musculoskeletal conditions for years.^{8,9} Specific attention should be given to proper patient selection.² Morey¹ reported that approximately 3% of patients who do not adequately respond to standard manipulation would come to require these MUA procedures.

Contraindications

Contraindications to MUA procedures may include those contraindications that apply to spinal manipulation procedures for patients who are conscious.⁷ In addition, the consulting medical physician must consider anesthesia risks to the patient. Contraindications include, but are not limited to, malignancy with metastasis to bone; tuberculosis of the bone or other infectious disease; recent fractures; acute arthritis; acute gout; uncontrolled diabetic neuropathy; syphilitic articular or periarticular lesions; gonorrheal spinal arthritis; excessive spinal osteoporosis; disk fragmentation; direct nerve root impingement that would contradict spinal manipulative therapy; and evidence of cord or caudal compression by tumor, ankylosis, or other space-occupying lesion. This includes severe spinal canal stenosis from any cause, which is considered to be the primary cause of the patient's symptoms and disability.¹⁰

General Procedures

Before the decision to perform MUA procedures, the physician and the patient discuss the options and possible outcomes. A 7-minute video presentation familiarizes the patient with the procedures, and typical patient questions are addressed before MUA procedures. This serves as additional informed consent. Risk is minimized by performing all spinal adjustments 3-dimensionally toward the center and opposite radiographically verified misalignments (instabilities). No forces are administered in the direction of instabilities present. Also, all motions are only taken to the expected normal ranges with guidance to the amount of the resistance relative to patient size, to tissue resistance, and to the unaffected side.

There are 3 distinct stages of the actual MUA procedure: (1) sedation of the patient; (2) specific chiropractic adjustments; and (3) passive stretching and traction procedures of the spine, sacroiliac, and pelvis. In the operating room are the anesthesiologist, the operating room nurse, the chiropractor in charge of the procedure (primary chiropractor), and an assistant chiropractor (secondary chiropractor). The patient is brought to the operating room and connected to the appropriate monitoring equipment and the appropriate amount of anesthesia is administered. This typically

includes the anesthesiologist's choice of propofol (Diprivan), midazolam (Versed), sufentanyl, and, occasionally, succinylcholine, through a secured IV in the dorsum of the hand. The patient reaches a deep conscious sedation in which he/she continues to breathe on his/her own and maintain normal oxygenation without the smooth muscle paralysis of full general (surgical) anesthesia patients.⁵ The principle drug used, propofol, is short acting and induces sedation and amnesia for the procedure. This drug allows the patient to awaken quickly, within 5 to 10 minutes,¹¹ and does not require intubation and the associated risks of long-acting paralytics and respiratory depression.⁷

A predetermined set of maneuvers are specified for every MUA patient, based on the areas of complaint and the decreased ranges of motion (ROMs). Maneuvers that may impose a particular risk to a patient, such as forced flexion with combined rotation in a patient with a disk herniation, are either modified or deleted from the protocols. The MUA procedures are typically repeated over the course of 3 days.

Lateral bending stress radiographs are taken before the MUA procedures to help direct treatment specifically at the fixated or hypomobile motion segments. This provides the chiropractor with some specific objective outcome goals, namely, improving ROM, globally and intersegmentally. The lateral bending radiographs are taken again after the second day to aid in planning the last day of the procedure for two reasons. One reason is to determine what effect the first 2 days of the MUA procedure had on the fixated and hypomobile spinal levels. Secondly, this process can help identify secondary problem areas that may be revealed by alleviation of the primary problems. These comparative x-rays allow the physicians to modify the treatment approaches more specifically to the patient's needs after the first 2 days of MUA.

Lumbar/Sacroiliac Spine Procedure

The lower extremities, lumbar spine, and sacroiliac joints are passively stretched to maximum end ROMs in flexion, lateral bending, distraction, and all rotations. The focus of these multiple maneuvers is to free fibrotic adhesions surrounding the lumbar spine, hip joints, pelvis, and lower extremities. These end-range pressures are sustained for 4 to 6 seconds with slight pressure increases during that period as allowed by the patient's tissue resistance. The second physician stabilizes the patient and provides counter-resistance to all mobilization maneuvers making the use of these directed forces possible.

The patient is then placed in a side posture position typically used for spinal adjustments with the superior knee flexed and stabilized by the second physician. The lumbar curve is placed in a neutral or slightly extended position. The upper torso is stabilized by cephalic and slight posterior pressure on the chest and shoulder. The lumbar spine is

taken to the end ROM removing slack from the surrounding tissues. Selected localization of known restricted segment(s) is performed. The elastic barrier of resistance is found with force delivered 3-dimensionally opposite to the direction of instability derived from the patient's radiograph. An HVLA thrust is applied and joint cavitation was achieved. The fixated sacroiliac articulation(s) is adjusted to assure optimal mobilization. The patient is then placed on the opposite side and the same procedure was repeated. The second physician provides patient stabilization on the table, assists in turning the patient into the side posture positions, and protects the IV and monitoring lines.

Thoracic Spine Procedure

The thoracic spine and the surrounding tissues are passively stretched in flexion, lateral bending, distraction, and rotation. Scapular distraction is used to release adhesions present in the paravertebral myofascial tissues. These end-range pressures are sustained for 4 to 6 seconds with slight pressure increases during that period as allowed by the patient's tissue resistance. The second physician stabilizes the patient, guards the IV and monitoring leads, and provides counter-resistance to allow the forces to be directed in a useful fashion.

With the patient lying on the table, the upper extremities were flexed at the elbows and crossed over the chest. Segmental localization of known restricted segment(s) is selected. One hand is placed over the selected thoracic segment and the other hand positioned over the crossed upper extremities. The elastic barrier of resistance is achieved and an HVLA thrust is applied in the direction opposite to the instability and cavitation is achieved, while the second physician sustains a slight caudal traction. The second physician provides assistance during the patient positioning, stabilizes the arms during this procedure, and protects the IV and monitoring lines.

Cervical Spine Procedures

The cervical spine and the surrounding soft tissues are passively stretched to maximum motion ranges in flexion, lateral bending, distraction, rotation, and oblique stretching angles. These end-range pressures are sustained for 4 to 6 seconds with slight pressure increases during that period as allowed by the patient's tissue resistance. The second physician provides counter-forces, as needed for the different procedures, and stabilizes the patient's arms to protect the IV and monitoring lines.

Axial traction was manually applied to the cervical spine while the second physician stabilizes the thorax with a slight caudal pressure. The involved cervical segment(s) is localized on one side and the elastic barrier of resistance is found. An HVLA thrust is applied opposite to the

Table 1. Pre- and post-MUA ROM measurements

	Patient 1		Patient 2		Patient 3		Patient 4	
	Pre-MUA	Post-MUA	Pre-MUA lumbar	Pre-MUA cervical	Pre-MUA	Post-MUA	Pre-MUA lumbar	Post-MUA lumbar
Extension	30°/30° ^c	30°/30° ^{nc}	30°/30° ^c	30°/55° ^{ab}	60°/60° ^a	80°/60° ^c	30°/30° ^{ac}	40°/30° ^c
Forward flexion	6° ^{ab,b}	4°-5° ^{nc}	1° ^{ab}	75°/75° ^{nc}	40°/50° ^{ab}	75°/50° ^{ac}	12° ^{ab,b}	0° ^{ab}
Right lateral flexion	25°/45° ^{ab}	Small change	50°/30° ^{ac}	45°/40° ^{ab}	30°/40° ^{ab}	40°/40° ^{ac}	15°/30° ^{ab}	40°/30° ^{nc}
Left lateral flexion	35°/45° ^{ab}	Small change	35°/30° ^{ac}	50°/40° ^{nc}	25°/40° ^{ab}	50°/40° ^{ab}	30°/30° ^{ab}	48°/30° ^{nc}
Right rotation	20°/30° ^{ab}	30°/30° ^{nc}	30°/30° ^{nc}	90°/80° ^{ab}	60°/80° ^{ab}	85°/80° ^{nc}	30°/30° ^c	36°/30° ^{nc}
Left rotation	30°/30° ^{nc}	30°/30° ^{nc}	30°/30° ^{nc}	90°/80° ^{nc}	50°/80° ^{ab}	80°/80° ^{nc}	20°/30° ^{ab}	34°/30° ^{nc}

^a To point of reported pain.

^b Fingertip inches from the ground.

^c No associated pain reported.

radiographically verified vertebral misalignment and cavitation was achieved. This procedure is repeated on the other side with continued assistance from the second physician.

A more aggressive approach to the most restricted regions is used based on patient tolerance to the MUA procedure after the first day. Spinal motions, which exhibited the most significant motion restrictions, were targeted more aggressively until normal or near normal motion ranges were obtained by the second and third day of the MUA procedures. Restricted articular and myofascial restrictions that were previously resistant released better with subsequent attempts.

After the MUA procedure, the patient is transferred to the recovery area, monitored until consciousness is regained and stability is achieved, and released from the recovery area in satisfactory condition to a responsible party for home transport.

Post-MUA Follow-up Procedure

The post-MUA follow-up procedures are considered second only to good patient selection as a determinant of a good outcome from MUA. These protocols are important to promote joint stabilization, patient independence, and decreased physician dependence.⁶ The 8-week, post-MUA, in-office articular and myofascial release procedures were designed to keep the decreased ROM and the intersegmental fixations from returning¹¹ during the healing process. The patient is seen 3 times weekly in the first month and twice weekly in the second month.

The following are components of the follow-up program: in-office spinal adjustments; replication of all traction maneuvers and stretches performed during MUA; cryotherapy; electrical stimulation; and an exercise-based functional restoration program initiated by the third week and continuing until the 8 weeks of the program are completed. This exercise program includes basic conditioning and addresses flexibility, strength, muscular balance, aerobic capacity, and proprioceptive coordination. The patients should continue

the exercise conditioning program after the 8 weeks, either in-office or at a home or private gymnasium. Other forms of adjunctive therapies, including myofascial release procedures and physiotherapeutic modalities, may also be used.

Trial of In-Office Chiropractic Care

It is thought that if the patient can tolerate it, a trial of standard spinal manipulation is warranted before MUA procedures should be performed.⁷ Rummey¹² suggests a trial period from 1 day to 6 weeks, whereas Francis¹³ recommends 5 to 6 weeks. Kohlbeck and Haldeman³ recommend a 4- to 8-week trial of conservative manipulative therapy before considering the more aggressive MUA approach. Francis and Beckett⁷ state that a "fair" trial of standard manipulation be given before MUA if acute pain does not prevent such a trial. If the patient does not adequately respond to standard manipulation, the attending clinician must ultimately make the decision to proceed with MUA procedures. Waiting too long to satisfy an arbitrary time requirement may delay the patient's recovery and allow further soft tissue or joint adhesions to develop.⁷

Case 1

A 38-year-old female patient had low back pain at the L4-5 vertebral levels and bilateral leg dysesthesias after referral from another chiropractor after 6 months of spinal adjustments to address her chronic symptoms. Acute episodes regularly occurred. She complained of difficulty sleeping and reported much crying, fear for the future, and increased disability. She stated that she was unable to play with her children and her condition was slowly worsening. She had a prior diagnosis as a "borderline" hypertensive.

Physical examination yielded unexceptional results except that her pulse rate was 99 beats per minute. She appeared her stated height of 5 ft 10 in and her stated weight of 200 pounds. No atrophy was noted in her lower

extremities. Neurologic examination was essentially normal with all deep tendon reflexes symmetrical and within normal limits. All muscle strengths of the lower extremities were normal at +5/5. Sensation of the lower extremities was found to be intact. Orthopedic examination revealed a slightly decreased ROM in forward flexion, right and left bending, and right rotation. Local signs of continued neuromechanical dysfunctions were still present at the L3 through S1 region primarily and secondarily in the lower thoracic spine and lower extremity myofascial tissues. These signs included functional x-ray-verified joint restrictions with pain and protective guarding, bilateral thermal alterations, and paraspinal edema. The lumbar ROMs of this patient on presentation before MUA are presented in Table 1.

Positive orthopedic tests included the straight leg raise (SLR) bilaterally at 85° causing low back pain; Patrick's FABERE test on the left side causing low back and hip pain; Ely's on the left side causing low back and hip pain; Hibb's bilaterally causing low back pain; and Yeoman's test on the left side causing low back pain. Kemp's maneuver was performed without leg pain, but with a report of tightness when performed on either side. The patient was able to walk on her toes and heels without difficulty. The sacroiliac compression test and Braggard's test were performed without symptoms.

Weight-bearing plain film lateral flexion stress radiographs revealed joint restrictions from L3 through S1 on the right and left sides. A lumbar magnetic resonance imaging (MRI) scan was performed and showed minimal annular disk bulging at L3-4 that did not impinge on the spinal canal or neural foramina. However, the L4-5 disk showed desiccation and loss of height, right paracentral protrusion that effaced the ventral thecal sac, and ligamentum flavum hypertrophy. Also evident were foraminal encroachment and mild spinal stenosis at this level. At the L5-S1 disk level, the MRI showed mild degenerative facet disease and ligamentum flavum hypertrophy.

Two weeks after the MUA procedures were performed, there were improvements in ROMs. Lumbar forward flexion allowed the patient's fingertips to reach approximately 4 in of reach from the floor. Lumbar rotation increased initially by approximately 15° in both directions and stabilized at 10°, and lateral flexion showed smaller improvements. Thoracic rotation improved from an average of 55° to 80° in each direction. The length of hamstring muscles increased. The patient improved subjectively and was able to participate in activities with her children. Her need for treatment decreased from at least 2 times weekly to approximately twice monthly. These results reflect observations up to 18 months post-MUA.

Case 2

A 28-year-old auto mechanic presented with neck pain, headaches, and low back pain resulting from being hit by a

car that was traveling approximately 30 mph. He was taken to an emergency department and referred for medical treatment, which included pain medication and physical therapy. Three months later, he was evaluated and was still on total temporary disability, being unable to perform the bending and lifting required for his essential job duties. He subsequently changed to chiropractic management and eventually was referred to our office. After a reasonable trial of chiropractic and an inadequate plateau being maintained, MUA was selected as an appropriate option.

Neurologic examination of the upper and lower extremities revealed a slight muscle weakness of the right hamstring muscle at +4/5. Deep tendon reflexes were all symmetrical and brisk at +2/5. Pinwheel testing of the upper and lower extremity dermatomes revealed decreased sensation of the right C7 and the right L4 dermatomes. Specific local signs of spinal injury were present at the C3, C7, and L3-5 spinal regions. These signs included paraspinal edema, spinous process tenderness, intersegmental motion restrictions, a sustained hyperemic response after deep digital palpation, and bilateral thermal asymmetries suggesting vertebral subluxations (neuromechanical dysfunctions) at these spinal regions. Weight-bearing plain film lateral bending stress radiographs were negative for fracture or other significant related pathology. Orthopedic examination revealed a slight decrease in ROM and increased pain upon several motions before MUA.

Positive orthopedic tests included the cervical compression on the left side causing neck pain and the shoulder depression test causing bilateral stiffness. Adson's test did not change the radial pulses. The SLR on the left side caused left calf and leg pain; the Patrick's FABERE test, when performed on the right side, caused right low back and hip pain. Braggard's test, when performed on the right side, caused right calf and leg pain. Kemp's maneuver caused low back and buttock pain when performed on the right side. The patient was able to walk on his toes and heels without difficulty. Ely's, sacroiliac compression, Hibb's, and Yeoman's tests were all performed without a production of symptoms.

Two weeks after the MUA procedures, the patient was nearly asymptomatic with normal ROM. He returned to his previous occupation after 1 month. Subsequently, he was treated with in-office spinal adjustments 1 to 2 times monthly for flare-ups that have not exceeded a 3 on a numeric pain scale (NPS) of maximum 10 intensity. Before the MUA procedure, his symptoms often increased to an NPS of 6 to 9. The patient reported an approximate 80% functional and symptomatic improvement from the treatment provided. These improvements were maintained up to 18 months post-MUA.

Case 3

A 34-year-old woman had cervical and thoracic pain, limited motion, and bilateral upper extremity dysesthesias

secondary to repetitive stress injuries related to her employment. She had been with her employer for 3 years and 2 months at the time of injury. Her duties required computer keyboard and mouse use for periods of time greater than 8 hours per day. The patient noticed a gradual onset of pain in her right forearm, right upper arm, and right shoulder region with pain radiating into her neck on the right side and bilaterally in her upper back. Headaches accompanied her right upper extremity and neck complaints, with symptoms rated at 5 to 7 on an NPS.

Initially upon seeking treatment, the patient had been given a "tennis elbow" brace and a shoulder sling to immobilize her right upper extremity by her medical physician; she was also provided a cortisone injection into her right wrist extensor musculature and Vicodin and ibuprofen for pain. After the medical treatment failed, she was referred for physical therapy with no appreciable response. At that point, the patient sought chiropractic care and was treated 3 times per week for 6 weeks. Treatments included specific intersegmental spinal adjustments, soft tissue mobilization, interferential current, home exercises to increase region and total body flexibility and strength, and ergonomic counseling. After a reexamination, the patient was treated at a frequency of 2 times per week for an additional 8 weeks. However, the patient did not show any significant lasting improvement. Finally, after 11 months from the initial treatment, the patient was referred for evaluation to determine her candidacy for MUA.

The cervical compression test was positive during right and left maximal cervical compression causing neck pain. The shoulder depression test was positive when performed on either side, causing increased neck pain. A modified Spurling's test was positive on the right and cervical distraction caused increased neck pain. Valsalva's and George's tests were negative. Neurologic examination revealed hypertonicity upon palpation of the right and left trapezius muscles, cervical and thoracic paraspinal musculature, right and left levator muscles, and the right and left scalene musculature. Deep tendon reflexes were symmetrical and normal. Upper extremity manual muscle testing was normal at +5/5 bilaterally. All cervical ROMs were decreased with pain provocation reported by the patient prior to the MUA procedures.

Specific signs of spinal intersegmental dysfunction (fixation) were noted at spinal levels C1-2, C5-6, and T6-7. Weight-bearing plain film lateral flexion stress radiographs were interpreted as evidence for abnormal coupling motion at the spinal levels of C1-2, C5-6, and T6-7. A cervical MRI failed to show any significant central canal or intervertebral foramen stenosis. Mild disk bulges were noted at the C5-6 and C6-7 levels.

Post-MUA, all orthopedic tests were negative, except that hypertonicity was noted upon palpation of the right trapezius muscle and pain on left lateral bending. Approximately 9 months post-MUA, at the request of the industrial

carrier, the patient was referred to an independent medical examiner for reevaluation. The examiner reported subjective complaints consistent with occasional neck stiffness reported at 1 to 2 on an NPS and virtually no upper back and headache complaints. The patient's only complaint related to her right upper extremity was intermittent pain localized to the wrist extensor musculature reported at 2 to 3 on an NPS. In comparison with 80 treatments during the prior year, the patient required only 7 chiropractic treatments over 9 months post-MUA.

Case 4

A 31-year-old, 10-year veteran worker at an automobile assembly plant had lumbar pain, limited motion, and bilateral lower extremity dysesthesias specific to the posterior thighs and plantar surfaces of his feet. The patient was injured 3 years prior as a transfer unit moved a vehicle he was working on and his tool gun struck him and threw him to the floor. Immediately after the accident, the patient experienced pain in his lower back, reported at 7 on an NPS, attendant lumbar paraspinal muscle spasm, and bilateral posterior thigh numbness. His employer directed him to seek occupational medicine care, and he was treated with Vicodin, Soma, and Motrin. After 3 weeks with no improvement, the patient underwent an 8-week treatment regimen of ultrasound, electrical muscle stimulation, moist heat, and floor exercises. He failed to improve and was referred for a lumbar MRI, which noted a 5-mm disk protrusion at the L5-S1 level. It was determined at this point that the patient was not a surgical candidate and was referred for a chiropractic evaluation and treatment. The patient continued to be on temporary total disability during 65 chiropractic treatments over the course of 7 months. Although he benefited from this chiropractic treatment, the patient desired further relief and was referred to these authors for the MUA procedure.

The patient's left SLR was positive at 50° and increased lower back and left lower extremity pain. The sitting SLR on the left increased lower back pain. Braggard's test was positive on the left and negative on the right. Kemp's maneuver on the left and right produced lower back and lower extremity pain, the lower extremity pain correlating to the side of the test. Patrick's FABERE test and Valsalva's were performed without symptoms. Neurologic examination revealed hypertonicity upon palpation of the paraspinal musculature spanning from T12 to S1, the left and right tensor fascia latae muscles, and the left external hip rotator muscles. Deep tendon reflexes were symmetrical and normal. Upper extremity manual muscle testing was normal at +5/5 bilaterally. Lumbar ROMs were decreased and painful in several planes of motion.

Specific signs of spinal intersegmental dysfunction were noted at T8-9 and L5-S1. Weight-bearing plain film lateral flexion stress radiographs showed abnormal coupling

motion at spinal levels T8-9, T12-L1, and L5-S1. A lumbar MRI revealed no evidence of significant central canal or intervertebral foramen stenosis, but the presence of a 5-mm disk protrusion at the L5-S1 level.

A follow-up examination was performed 12 weeks after the patient's MUA procedures. The patient reported subjective complaints that were consistent with occasional low back discomfort reported at 2 on an NPS. He further reported complete resolution of his bilateral lower extremity complaints. All orthopedic tests were essentially negative and ROMs were normal. The patient returned to full duty with his original employer, working without restriction on the automobile assembly line. Twelve months later, the patient had received a total of 8 chiropractic treatments on an as-needed basis, as compared with 65 treatments received over the 7 months before his MUA.

DISCUSSION

The 4 cases presented in this study show an application of MUA to patients who tolerate in-office chiropractic adjustments, but failed to progress to functional and acceptable asymptomatic levels. The patients presented with a diagnosis of vertebral subluxation complex (neuro-mechanical dysfunction) complicated by myofascial and articular fibrosis, although the patient histories, the physical examination findings, and the spinal regions affected with each patient were different.

The authors are not suggesting that the results seen with these patients are representative or predictive of results expected on any individual case in a larger population. Results with more aggressive procedures for chronic spinal pain may be expected to offer help for a lesser percentage of patients because only the most complicated and advanced cases are undergoing these MUA procedures. However, Siehl and Bradford⁸ reported that 60% of their 87 MUA patients had good or excellent results. Siehl⁹ also reported 71% "good" results in the 723 cases reported in 1963.

The authors have seen very favorable responses with an estimated 10% showing no substantial improvement. Our postprocedure quality assurance telephone calls to patients performed by nurses showed that an estimated 70% were "very satisfied," consistent with the findings of others in the reported literature. The remaining 20% of favorable responses noted above were described by patients as "satisfied." No patients seen in our offices reported a worsening of their condition once their expected postprocedure symptoms subsided. We have studied these cases to assist in future improvements in patient selection. Similar to Siehl⁹ and Bradford,⁸ Vannetiello and Soto reported in an internal retrospective quality review (Bay Area Ambulatory Care Center) using patient questionnaires that approximately 70% of the patients treated with MUA improved substantially with clear and significant pain reduction, functional

capacity increases, and disability reductions. This retrospective review also showed that approximately 30% of these 400 patients had results exceeding simple improvements, including some apparent autonomic nerve mediated and general health benefits. In one patient, a long-standing vertigo that caused frequent falls was abolished without return of symptoms on an 11-month follow-up. In another, drug medication was reduced by 75% in a patient with disabling daily headaches. In another, posttraumatic daily headaches were abolished after the second day of these procedures and did not return. Patients on total temporary disability from work for periods of 3 to 50 months returned to work successfully within a 2- to 16-week period. One patient included in these studies went from being totally temporarily disabled to playing professional football in a 6-month period. Similarly, West et al² reported a very favorable reversal in patients out of work before MUA (68.6%) and those returning to unrestricted activities at 6 months after MUA (64.1%). In addition, perhaps most importantly, functional capacity losses were reduced, allowing patients to return to numerous recreational and family-related activities that improved their lives substantially.

Other studies support the efficacy and safety of the MUA process for properly selected patients over the past several decades. Kohlbeck and Haldeman³ provide a literature review of MUA (49 articles) that concluded the following: medication-assisted spinal manipulation therapies have a relatively long history of clinical use and have been reported in the literature for more than 70 years. However, evidence for the effectiveness of those protocols remains largely anecdotal, based on a case series mimicking many other surgical and conservative approaches for the treatment of chronic pain syndromes of musculoskeletal origin.³

Considering the high cost of managing these patients, the number of patients with this type of complaint, and the resultant negative effects on these patient's lives, further studies in the area of MUA, such as randomized clinical controlled trials, are recommended.

CONCLUSIONS

The 4 patients presented in this series initially failed to show lasting improvement from a trial of typical chiropractic management and conservative medical care; however, they improved with MUA. Manipulation under anesthesia may be an effective option for patients with chronic pain who have not adequately improved with in-office chiropractic or other adjunctive approaches.

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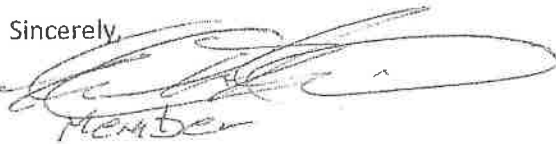
Melanie Hill, Executive Director
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Re: Spinal Health Care Associates, P.C.

Dear Ms. Hill,

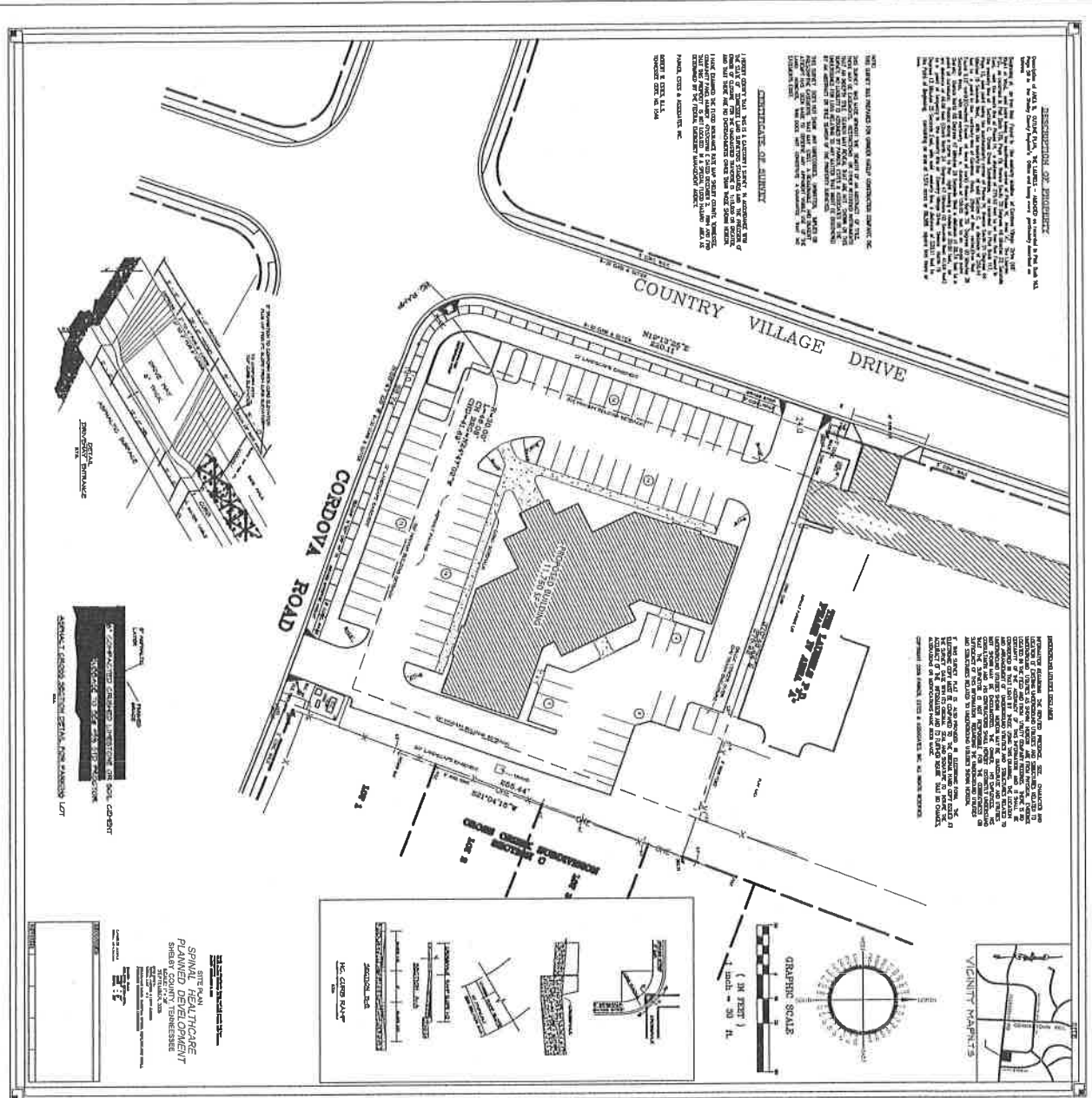
As the potential contractor for the proposed renovation and build out of Spinal Health Care Associates, P.C., I have reviewed the costs set aside for the construction required, and believe that \$110,000 is a sufficient estimate to complete this build out. The estimate was prepared to be compliant with all applicable federal, state and local construction codes, standards, specifications, and requirements, and the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the new 2010 AIA Guidelines for Design and Construction of Health Care Facilities.

Sincerely,



Member

Kevin B. Richardson
Interior Construction Solutions, LLC



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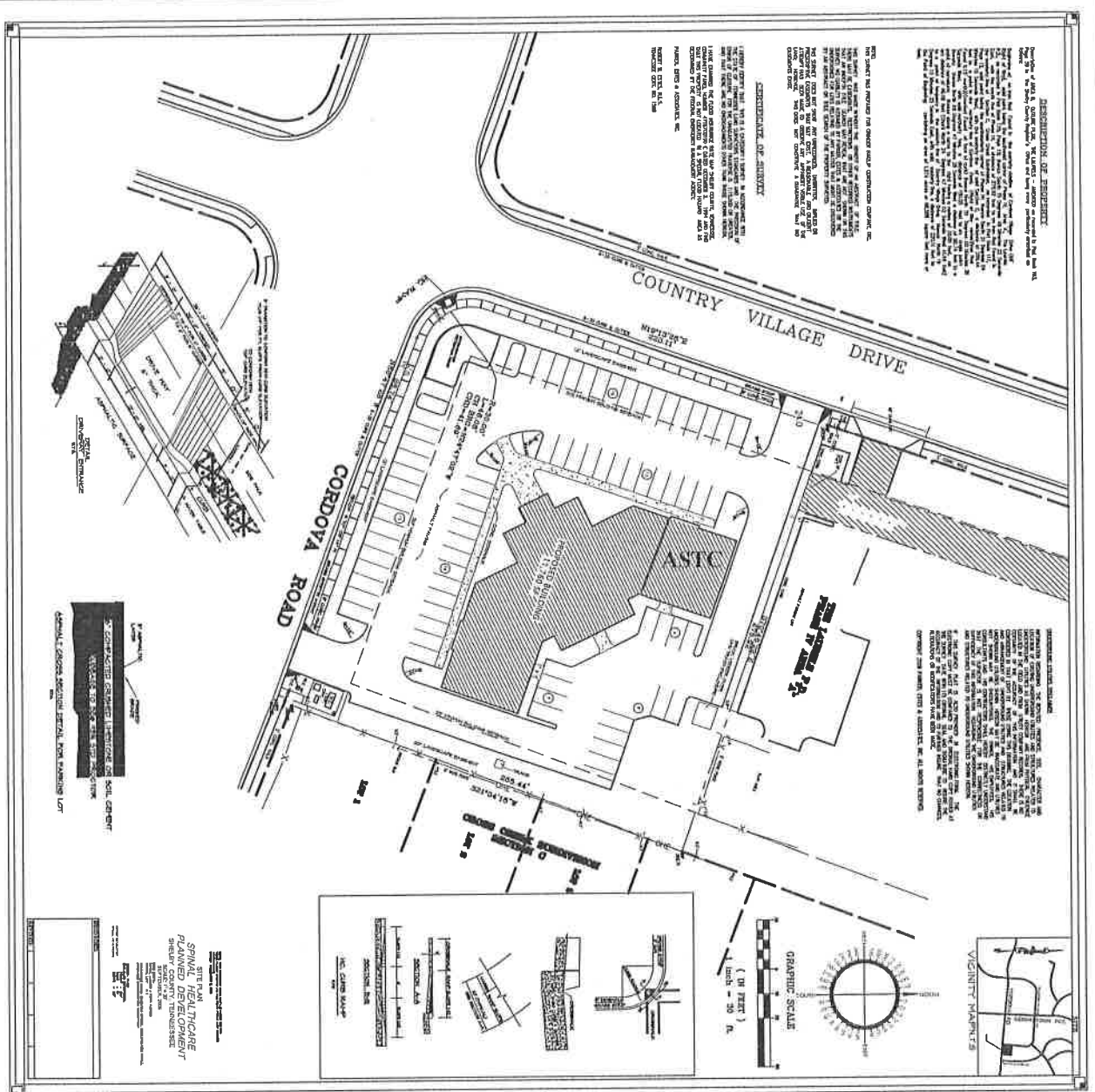
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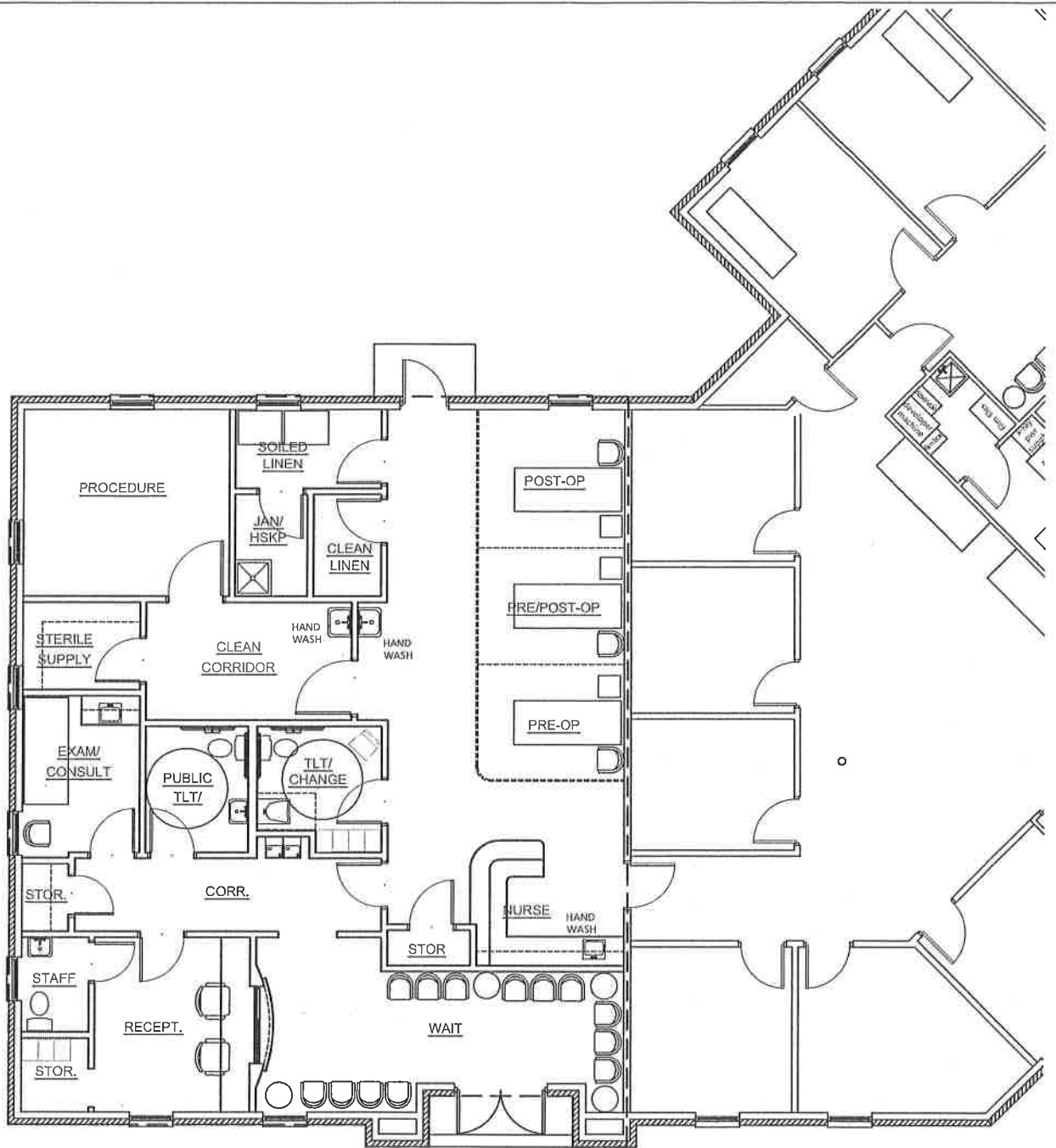
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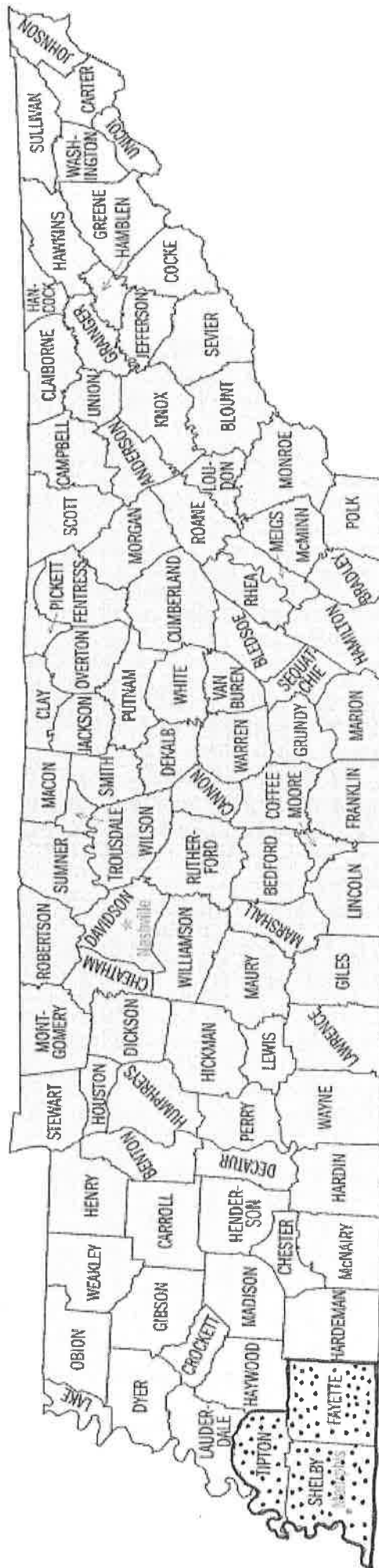
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DATE: 11-9-12

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Tennessee County Map

Attachment C.Need.3



Attachment C.Need.4.A

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State & County QuickFacts

Fayette County, Tennessee

People QuickFacts	Fayette County	Tennessee
Population, 2011 estimate	38,513	6,403,353
Population, 2010 (April 1) estimates base	38,413	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	0.3%	0.9%
Population, 2010	38,413	6,346,105
Persons under 5 years, percent, 2011	6.3%	6.3%
Persons under 18 years, percent, 2011	22.6%	23.3%
Persons 65 years and over, percent, 2011	15.5%	13.7%
Female persons, percent, 2011	50.3%	51.3%
White persons, percent, 2011 (a)	70.3%	79.5%
Black persons, percent, 2011 (a)	28.0%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.3%	0.4%
Asian persons, percent, 2011 (a)	0.6%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	0.1%
Persons reporting two or more races, percent, 2011	0.8%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	2.4%	4.7%
White persons not Hispanic, percent, 2011	68.2%	75.4%
Living in same house 1 year & over, 2006-2010	89.7%	83.8%
Foreign born persons, percent, 2006-2010	2.0%	4.4%
Language other than English spoken at home, pct age 5+, 2006-2010	3.6%	6.2%
High school graduates, percent of persons age 25+, 2006-2010	82.8%	82.5%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	18.9%	22.7%
Veterans, 2006-2010	2,865	505,746
Mean travel time to work (minutes), workers age 16+, 2006-2010	33.0	23.9
Housing units, 2010	15,669	2,812,133
Homeownership rate, 2006-2010	83.3%	69.6%
Housing units in multi-unit structures, percent, 2006-2010	4.1%	18.1%
Median value of owner-occupied housing units, 2006-2010	\$170,400	\$134,100
Households, 2006-2010	13,498	2,443,475
Persons per household, 2006-2010	2.72	2.49
Per capita money income in past 12 months (2010 dollars) 2006-2010	\$26,898	\$23,722
Median household income 2006-2010	\$56,729	\$43,314
Persons below poverty level, percent, 2006-2010	13.0%	16.5%
Business QuickFacts	Fayette County	Tennessee
Private nonfarm establishments, 2009	590	132,901 ¹
Private nonfarm employment, 2009	6,314	2,317,986 ¹
Private nonfarm employment, percent change 2000-2009	49.9%	-3.0% ¹
Nonemployer establishments, 2009	2,946	448,516
Total number of firms, 2007	3,779	545,348
Black-owned firms, percent, 2007	15.3%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	S	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	S	1.6%
Women-owned firms, percent, 2007	23.0%	25.9%
Manufacturers shipments, 2007 (\$1000)	889,776	140,447,760

Merchant wholesaler sales, 2007 (\$1000)	74,398	80,116,528
Retail sales, 2007 (\$1000)	126,612	77,547,291
Retail sales per capita, 2007	\$3,402	\$12,563
Accommodation and food services sales, 2007 (\$1000)	12,553	10,626,759
Building permits, 2011	125	14,977
Federal spending, 2010	291,166	68,865,540 ¹

Geography QuickFacts	Fayette County	Tennessee
Land area in square miles, 2010	704.79	41,234.90
Persons per square mile, 2010	54.5	153.9
FIPS Code	047	47
Metropolitan or Micropolitan Statistical Area	Memphis, TN-MS-AR Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.

(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information

F: Fewer than 100 firms

FN: Footnote on this item for this area in place of data

NA: Not available

S: Suppressed; does not meet publication standards

X: Not applicable

Z: Value greater than zero but less than half unit of measure shown

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
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State & County QuickFacts

Shelby County, Tennessee

People QuickFacts	Shelby County	Tennessee
Population, 2011 estimate	935,088	6,403,353
Population, 2010 (April 1) estimates base	927,644	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	0.8%	0.9%
Population, 2010	927,644	6,346,105
Persons under 5 years, percent, 2011	7.2%	6.3%
Persons under 18 years, percent, 2011	26.1%	23.3%
Persons 65 years and over, percent, 2011	10.4%	13.7%
Female persons, percent, 2011	52.3%	51.3%
White persons, percent, 2011 (a)	43.6%	79.5%
Black persons, percent, 2011 (a)	52.3%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.4%	0.4%
Asian persons, percent, 2011 (a)	2.4%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.3%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	5.8%	4.7%
White persons not Hispanic, percent, 2011	38.6%	75.4%
Living in same house 1 year & over, 2006-2010	81.6%	83.8%
Foreign born persons, percent, 2006-2010	6.0%	4.4%
Language other than English spoken at home, pct age 5+, 2006-2010	8.5%	6.2%
High school graduates, percent of persons age 25+, 2006-2010	84.9%	82.5%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	27.8%	22.7%
Veterans, 2006-2010	62,382	505,746
Mean travel time to work (minutes), workers age 16+, 2006-2010	22.4	23.9
Housing units, 2010	398,274	2,812,133
Homeownership rate, 2006-2010	61.7%	69.6%
Housing units in multi-unit structures, percent, 2006-2010	27.6%	18.1%
Median value of owner-occupied housing units, 2006-2010	\$135,300	\$134,100
Households, 2006-2010	340,443	2,443,475
Persons per household, 2006-2010	2.65	2.49
Per capita money income in past 12 months (2010 dollars) 2006-2010	\$25,002	\$23,722
Median household income 2006-2010	\$44,705	\$43,314
Persons below poverty level, percent, 2006-2010	19.7%	16.5%
Business QuickFacts	Shelby County	Tennessee
Private nonfarm establishments, 2009	20,262	132,901 ¹
Private nonfarm employment, 2009	428,357	2,317,986 ¹
Private nonfarm employment, percent change 2000-2009	-10.3%	-3.0% ¹
Nonemployer establishments, 2009	70,282	448,516
Total number of firms, 2007	76,350	545,348
Black-owned firms, percent, 2007	30.9%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.3%	0.5%
Asian-owned firms, percent, 2007	3.4%	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	0.1%	0.1%
Hispanic-owned firms, percent, 2007	1.7%	1.6%
Women-owned firms, percent, 2007	30.8%	25.9%
Manufacturers shipments, 2007 (\$1000)	17,969,681	140,447,760

Merchant wholesaler sales, 2007 (\$1000)	29,636,012	80,116,528
Retail sales, 2007 (\$1000)	11,932,863	77,547,291
Retail sales per capita, 2007	\$12,971	\$12,563
Accommodation and food services sales, 2007 (\$1000)	1,787,964	10,626,759
Building permits, 2011	1,400	14,977
Federal spending, 2010	10,393,200	68,865,540 ¹

Geography QuickFacts	Shelby County Tennessee	
	County	
Land area in square miles, 2010	763.17	41,234.90
Persons per square mile, 2010	1,215.5	153.9
FIPS Code	157	47
Metropolitan or Micropolitan Statistical Area	Memphis, TN-MS-AR Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.

(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information

F: Fewer than 100 firms

FN: Footnote on this item for this area in place of data

NA: Not available

S: Suppressed; does not meet publication standards

X: Not applicable

Z: Value greater than zero but less than half unit of measure shown

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
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State & County QuickFacts

Tipton County, Tennessee

People QuickFacts	Tipton County	Tennessee
Population, 2011 estimate	61,293	6,403,353
Population, 2010 (April 1) estimates base	61,081	6,346,110
Population, percent change, April 1, 2010 to July 1, 2011	0.3%	0.9%
Population, 2010	61,081	6,346,105
Persons under 5 years, percent, 2011	6.4%	6.3%
Persons under 18 years, percent, 2011	26.9%	23.3%
Persons 65 years and over, percent, 2011	11.4%	13.7%
Female persons, percent, 2011	51.0%	51.3%
White persons, percent, 2011 (a)	78.3%	79.5%
Black persons, percent, 2011 (a)	18.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	0.6%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.7%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	2.3%	4.7%
White persons not Hispanic, percent, 2011	76.4%	75.4%
Living in same house 1 year & over, 2006-2010	84.7%	83.8%
Foreign born persons, percent, 2006-2010	1.4%	4.4%
Language other than English spoken at home, pct age 5+, 2006-2010	2.4%	6.2%
High school graduates, percent of persons age 25+, 2006-2010	83.2%	82.5%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	13.8%	22.7%
Veterans, 2006-2010	5,455	505,746
Mean travel time to work (minutes), workers age 16+, 2006-2010	31.8	23.9
Housing units, 2010	23,199	2,812,133
Homeownership rate, 2006-2010	74.2%	69.6%
Housing units in multi-unit structures, percent, 2006-2010	6.7%	18.1%
Median value of owner-occupied housing units, 2006-2010	\$135,100	\$134,100
Households, 2006-2010	21,235	2,443,475
Persons per household, 2006-2010	2.74	2.49
Per capita money income in past 12 months (2010 dollars) 2006-2010	\$21,585	\$23,722
Median household income 2006-2010	\$49,378	\$43,314
Persons below poverty level, percent, 2006-2010	16.7%	16.5%
Business QuickFacts	Tipton County	Tennessee
Private nonfarm establishments, 2009	768	132,901 ¹
Private nonfarm employment, 2009	8,408	2,317,986 ¹
Private nonfarm employment, percent change 2000-2009	-13.4%	-3.0% ¹
Nonemployer establishments, 2009	3,699	448,516
Total number of firms, 2007	3,817	545,348
Black-owned firms, percent, 2007	9.4%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	S	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	S	1.6%
Women-owned firms, percent, 2007	26.9%	25.9%
Manufacturers shipments, 2007 (\$1000)	774,196	140,447,760

Merchant wholesaler sales, 2007 (\$1000)	241,853	80,116,528
Retail sales, 2007 (\$1000)	404,163	77,547,291
Retail sales per capita, 2007	\$7,002	\$12,563
Accommodation and food services sales, 2007 (\$1000)	29,779	10,626,759
Building permits, 2011	61	14,977
Federal spending, 2010	437,822	68,865,540 ¹

Geography QuickFacts	Tipton County	Tennessee
Land area in square miles, 2010	458.37	41,234.90
Persons per square mile, 2010	133.3	153.9
FIPS Code	167	47
Metropolitan or Micropolitan Statistical Area	Memphis, TN-MS-AR Metro Area	

¹: Includes data not distributed by county.

(a) Includes persons reporting only one race.

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Policies and Procedures for Manipulation Under Anesthesia

Robert C. Gordon, D.C., FABCS, FRCCM, DAAPM

Purpose

The purpose of writing these policies and procedures is for facilities or doctors or the staff of a facility to have a guideline for providing the service of the technique of Manipulation Under Anesthesia (MUA). It will be used in conjunction with the National Academy of MUA Physicians standards and protocols, and will be used to determine the types of doctors who may use the facilities for MUA; the educational standards required for staff privileges for the use of MUA; for the patient logistical movement in the facility; the required policy for the use of the MUA procedure; the basis for clinical selection of cases for the MUA procedures; the accepted and suggested follow-up post care requirement for the MUA patients; and for the overall guidelines for the MUA procedures that may not be part of the mentioned areas above.

Educational Standards

It shall be the policy of this facility that the doctors that are performing this procedure must have achieved 36 hours of postgraduate instruction in MUA from a CCE/CME accredited Chiropractic or Medical school, and that those hours contain education in: The history of the MUA procedure; the scientific basis of the MUA procedure; the clinical application of the patients for MUA; the proper selection of the patients for MUA (use of the NAMUAP standards and protocols); two week-ends of education in MUA consisting of a didactic education and workshops, an examination both oral and written, and a second week-end which allows the doctors to be proctored on actual patients with hands on training in the MUA procedure. This standard of education has long been the standard of education for MUA since its inception, and has been taught by the original MUA instructors since the late 80's in the chiropractic profession. Since the MDs and the DOs have no formal MUA program at this time in their institutions most MDs and DOs have been taking their training from the chiropractic profession. There is a preponderance of evidence that the education of the doctors performing this procedure must follow extensive standards that have long been the standard of education to understand the full process of MUA. There is also evidence that if proper education in the area of billing and working with insurance companies is not completed properly there is no proper follow-up for graduating doctors, and therefore no education in the proper use of coding, and fee structures. This should be considered when a doctor becomes a part of a facility. The doctors that use this facility must have an idea of proper billing procedures, and must follow standards that allow for conservative billing practices as taught in the long standing older courses. The older courses still teach proper billing practices and therefore will be used as the gold standard for any doctor that has taken the training.

Proper Patient Selection

It shall be the policy of the facility that the proper selection of patients for this procedure should be foremost in the mind of the practitioner of MUA. Proper selection of the patient is the purest form of proper outcomes, and the essence of a good MUA program is the highest recovery rate possible from those patients selected to undergo MUA. The use of the National Academy of

MUA Physicians is a good start for this section. Other algorithms that follow standard care for various conditions may also be formatted to fit this particular section, and may be included in additional appendixes within this policies and procedures protocols.

Clinical Efficacy of Manipulation Under Anesthesia(MUA)

It has long been the practice of the doctor involved in physical medicine and chiropractic that the movement, mobilization, manipulation, and adjusting of joints, joint capsules, and surrounding holding elements (muscles, ligaments, and tendons) of aberrant articulations can decrease the patients pain and increase range of motion. Literature and reference of all kinds for many years has contended, and research has proven that to relocate abnormal articulations and correct misalignment from biomechanical abnormalities creates an atmosphere of correction and recovery from which patients respond very well. The chiropractic profession, as well as the osteopathic profession, have long stood behind these practices, and the medical profession in most recent years have also given credence to mobilization and manipulation as a real alternative to other frequently used methods of medical pharmacologic intervention or surgery.

Manipulation under anesthesia is a modality which has been used by all of the above mentioned practitioners since the early 30's to bring about the correction of biomechanical abnormalities that would only respond minimally to conservative office based manual therapy in its various forms. The object and therefore the clinical justification for the use of MUA is simply to relax the patient and then make the corrections in the biomechanical abnormality by means of stretching mobilization and manipulation of the articulations that are involved in the abnormal mechanical alteration. If the right anesthesia is introduced in a proper environment that allows the patient to respond, but be less apprehensive and have less discomfort, the practitioner who has MUA certificate training is better able to make corrections such that the patient gains back range of motion and therefore is relieve of neurological stressors that cause painful response while they are being compressed. To make more out of this than this simple statement is complicating a very well received and very well used procedure that causes many recoveries that would not respond if not for this procedure being used.

Clinically we are basically taking arthrokinectic dysfunctional anatomy which is causing fibroblastic proliferative changes (adhesions) to be formed, altering them, and giving back normal movement and in the process decreasing pain and dysfunction.

Patient Selection Criteria

In conjunction with the National Academy of MUA Physicians and following their standards and protocols the following would be indicated but may not be limited to: Following the standards of proper care as outlined by the NAMUAP standards and protocols which calls for a minimum of 4-6 weeks of conservative manual therapy care:

1. The patient must exhibit pain and or muscle spasm/contracture documented by three of the following:
 - a. Observation
 - b. Palpation

- c. Visual analog scale
 - d. Measurement (algometry)
 - e. History
 - f. Objective testing such as MRI, CT, EMG, Surface EMG, Mechanical Dermatomal alteration, or other well established diagnostic testing modalities.
 - g. Standardized pain questionnaire such as Oswestry or Roland Morris
2. The patient must also be diagnosed as having a primary neuromusculoskeletal complaint as the primary cause of the patients complaint using the standard MUA protocols for MUA patient selection criteria (NAMUAP).
 3. The patient's diagnosed condition must interfere with the patient's **activities of daily living** as outlined in the history and physical, and fall within the standard **indications** for MUA, as referenced in: "Manipulation Under Anesthesia, Concepts In Theory and Application", R. Gordon, April 2005, Taylor and Francis, and the NAUMAP standards and protocols.
 4. Sufficient care has been rendered prior to MUA selection as referenced above.
 5. The patient has been informed of other treatments that might also be available, but has chosen to proceed with the MUA procedure after adequate explanation of the risks and benefits.

Medical Clearance and Standardized Review

Medical clearance is required for MUA just like medical clearance is required for any procedure completed under anesthesia. The requirements for medical clearance vary for each state, and each facility and the anesthesiologists requirements before anesthesia is provided. This determines what the standard testing will be required before the patient undergoes MUA. In general the class one patient will be required to have a physical examination involving all systems, heart, respiratory system, liver, abdomen, eyes nose and throat, and complete musculoskeletal and neurological work up. Blood work that is required is usually minimal (ex. SMAC 6) just to rule out any problems that might prevent excretion of medicines and slow metabolism etc.. Most facilities also require that the patients over 40-50 undergo an EKG, and if respiratory problems are suspected, or asthma, a chest x-ray. Since we only choose patients that fall within the class 1 or with evaluation class 2 anesthesia criteria, these tests are fairly routine in most facilities.

The other requirement is for medical supervision and oversight. Medical presence should be part of the team approach for MUA. It should be remembered that this not a one type of physician procedure. This is a team procedure and cannot be accomplished by one or even two practitioners. We teach in class that this is not a chiropractic procedure but rather a procedure that chiropractic physicians take part in. In order for this procedure to be completed there needs to be a medical clearance physician as mentioned above, there needs to be anesthesia clearance and an anesthesia practitioner involved, there needs to be medial oversight, there needs to be two

trained MUA practitioners to perform the procedure, and there needs to be nursing supervision of the patient during and after the procedure in recovery before the patient is sent home.

Treatment Protocols

1. The following must be considered when considering the treatment and the numbers of treatments necessary to achieve the desired results in the MUA field:
 - a. Chronicity
 - b. Length of current conservative therapy program
 - c. Patients age
 - d. Numbers of previous injuries to the same area
 - e. Level of unimproved pain
 - f. Patient acceptance
 - g. Muscle contracture (beyond splinting)
 - h. Interference with activities of daily living (ADLs)
 - i. Augmentation of adhesion build up, esp. with failed back surgery
 - j. Possible surgical intervention if MUA is not tried at this juncture of the patient's recovery. Serial MUA considered to prevent surgery where one procedure might still make the patient a surgical candidate, three or four MUAs might prevent the surgical intervention (ref. NAMUAP).
2. The usual and customary protocols for MUA have been to provide serial fashion MUA, where the procedure is repeated in three successive days. This approach over the years has proven to be very beneficial to the patient, and has been clinically justified by the referenced fact that when correcting adhesion build up, if collagen fibers are not addressed during remodeling in an intensive format, which is what MUA does, then adhesions (or fibroblastic proliferative tissue) begins to reform in 24-48 hours. It is the contention by the MUA community that if we were to allow for one MUA to be performed, and then waited a week to do another one etc., then the process of reformation and remodeling would not take place, but rather the adhesion would reform again. In doing that we would be constantly working to control the reformation of the adhesions that had formed over the period of time since the patient was injured. It has been shown doing MUA in serial fashion and based on the references that performing multiple MUAs and then following the MUAs with immediate post MUA care to be described later in these policies and procedures, that the adhesions do not form back as before as evidenced by the patient gaining considerable range of motion and decreased pain and in many cases an 80 to 90% recovery with the proper patient selection.
3. Post MUA Care – is without a doubt, one of the most important phases of the MUA procedure. With the fibroblastic proliferative tissues altered in an intensified manner, the joints, joint capsules, and the surround holding elements must undergo continuous motion and joint manipulation/adjusting to help reform those collagen fibers in order to maintain the status of improvement that was achieved during the MUA procedure. In the past, post care was carried on in a normal conservative fashion, however, it is now believed that immediate intensified post care consisting of immediate same day therapy using the exact

same stretches that were used during the MUA procedure; followed by 7-10 days of continuous motion, mobilization and manipulation with minimal resistance, followed by 2 weeks of pre-rehabilitation using slight to moderate resistive forces, and then 4 weeks of formal circuit training rehabilitation will give the best outcomes. This regime has been used over and over by the MUA community, and has been found to be the best approach to maintaining the improvement that was achieved during the MUA procedure itself. Since the end result of this procedure is recovery from the conditions that were chosen to receive the MUA procedure, and to maintain the status post recovery, the patient has to undergo changes in their life style, and feel a sense of accomplishment in not only the therapy that was administered using the MUA procedure, but in their own benefit by their participation in the recovery process.

Operative Procedure (this report is a guideline and sample for the full spine procedure referenced in the textbook, "Manipulation Under Anesthesia, Concepts In Theory and Application; R. Gordon...it is not meant to replace standard documentation specifically dictated for each procedure for each day the patient undergoes MUA.) Also note that extra spinal techniques have not been presented but should be dictated for each area treated.

PROCEDURES PERFORMED:

1. Manipulation of the hip joint requiring general anesthesia, **RIGHT & LEFT;**
CPT 27275 x 2 – 51
2. Manipulation under anesthesia, shoulder joint, **RIGHT & LEFT;** CPT 23700 x 2 – 51
3. Manipulation of the spine requiring anesthesia, **CERVICAL, THORACIC, & LUMBAR** regions; CPT 22505 x 3 – 51

PRE-OP DIAGNOSIS: (Example)

1. Displacement of Thoracic and/or Lumbar IVD without Myelopathy (ICD-9 722.1)
2. Displacement of cervical IVD without Myelopathy (ICD-9 722.0)
3. Myalgia and Myositis; cervical, thoracic, lumbar, bilateral shoulder/peri-scapular musculature, pelvic girdle musculature, and bilateral hip regions (ICD-9 729.1)
4. Spasm of muscle/muscle hypertonicity; cervical, thoracic, lumbar, bilateral shoulder/peri-scapular musculature, pelvic girdle musculature, and bilateral hip regions (ICD-9 728.85)

POST-OP DIAGNOSIS:

Same as Pre-op Diagnosis

INFORMED CONSENT:

After adequate explanation of the medical, surgical, and procedural options, this patient has decided to proceed with the recommended spinal Manipulation Under Anesthesia. The patient has been informed that more than one procedure may be necessary to achieve satisfactory results.

INDICATION:

Upon review of the patient's history and supplied medical records the patient has been found a good candidate for manipulation under anesthesia. The standards of protocol being followed are set forth by the National Academy of MUA Physicians.

COMMENTS:

The patient understands the essence of the diagnosis and the reasons for MUA. The associated risks of the procedure, including anesthesia complications, fracture, vascular accident, disc herniation, and post-procedure discomfort, were thoroughly discussed with the patient. Alternatives to the procedure, including the course of the

condition without MUA were discussed. The patient understands the chances of success from undergoing MUA and that no guarantees are made or implied regarding outcome. The patient has given both verbal and written informed consent for the listed procedure.

THE PROCEDURE IN DETAIL:

The patient's pain level today was 8 out of a possible 10 (10 being the worst imaginable pain)

The patient was draped in appropriate gowning and was taken by gurney to the operative area and asked to lie supine on the operative table. The patient was then placed on the appropriate monitors for this procedure. When the patient and I were ready, the anesthesiologist administered the appropriate medications to assist the patient into twilight sedation using medications which allow the stretching, mobilization, and adjustments necessary for the completion of the outcome desired.

THE CERVICAL SPINE:

The patient's arms were crossed and the patient was approached from the rostral end of the table. Long axis traction was applied to the patient's cervical spine and musculature while counter-traction was applied by the co-attending doctor. The co-attending doctor was positioned to stabilize the patient's shoulders in order to use this counter-traction maneuver. Traction in the same manner was then applied into a controlled lateral coronal plane bilaterally, and then in an oblique manner by rotating the patient's head to 45 degrees and elevating the head toward the patient's chest. This was also accomplished bilaterally. At no time was the patient taken past the physiological barrier. The patient's head was then brought into a neutral posture and cervical flexion was achieved to traction the cervical paravertebral muscles. The cervical spine was then taken into a lateral traction maneuver to achieve specific closed reduction manipulation of vertebral elements at the cervical spine on the right side and again using the same technique on the left side of the cervical spine. During this maneuver, a low velocity thrust was achieved after taking the vertebrae slightly past the elastic barrier of resistance. Cavitations were achieved.

SHOULDER THORACIC LIFT:

With the patient in the supine position, the doctor distracts the right arm straight/superior cephalad to end range. This is accomplished on both sides to release thoracic elements before the thoracic adjustment.

SHOULDER:

With the patient in the supine position the doctor stands on the side of involvement. The doctor takes the patient's arm in the bent arm position and tractions up away from the patient's body and tucks the extremity into the doctor's abdominal area. The doctor has contact at the crook of the patient's bent arm and support contact on the patient's lateral shoulder area over the mid deltoid area. In this position, the attending doctor then walks the extremity forward into forward flexion noting range of motion and patient's resistance. Once the extremity and thus the shoulder was taken into forward flexion the next move was to leave the contact hand in place and do an adduction traction over the doctor's hand toward the middle of the patient's body. The next move was then to relocate position so that internal and external ranges of motion are performed. The attending doctor can take the shoulder through simple external and internal ranges of motion on the first day and then become more aggressive on the following days by contacting the upper extremity up near the axial and doing internal and external rotation closer to the body.

The next part of the procedure is the same forward flexion maneuver with the arm straight. Traction is accomplished by contacting the wrist, tucking the arm in close to the doctor, and then walking the arm forward into forward flexion. Then the same adduction move is accomplished with the doctor keeping the arm straight and tractioning the arm over his or her hand toward mid line of the body. Next the doctor stands at the head of the patient and lowers the patient's arm to his side. Forward flexion is then accomplished with a knife edge contact at the acromioclavicular humeral joint area. Traction is made during forward flexion into the knife edge and a slight thrust into the joint is made.

The attending doctor then assumes the forward position and tractions the arm up and away and at the same time rotates his hip into the axillary area. This opens up the joint space and the doctor contacts the lateral border of the clavicle and administers three short toggle thrusts into the area with a pisiform contact. The thrusts are not directed into the clavicle but the line of drive is more toward the lateral clavicle and the medial border of the humerus.

The patient is then placed in the side lying position and circumduction clockwise and counterclockwise is accomplished by contacting the head of the humerus. This maneuver is accomplished by the doctor cupping the hands with interwoven fingers around the head of the humerus and the movements are very small and deliberate.

Once all these maneuvers are accomplished the doctor then completes the A to P manipulative procedure. Contact is at the cephalad border of the pectoralis major with support for the scapula and at the anterior aspect of the humeral glenoid cavity joint. The thrust is a motion that mimics the relocation of the head of the humerus into the glenoid cavity. The movement is up and over the shoulder with respect to line of drive.

THE THORACIC SPINE:

With the patient in the supine position on the operative table, the upper extremities were flexed at the elbow and crossed over the patient's chest to achieve maximum traction to the patient's thoracic spine. The co-attending doctor held the patient's arms in the proper position and assisted in rolling the patient for the adjustive procedure. With the help of the first assistant, the patient was rolled onto their side, selection was made for the contact point and the patient was rolled back over the doctor's hand. The elastic barrier of the resistance was found, and a low velocity thrust was achieved using a specific closed reduction anterior to posterior manipulative procedure. This same procedure was repeated at the upper, middle, and lower thoracic regions.

MEDIAL SCAPULAR BORDER LIFT:

With the patient in the side lying position, the patient's lower arm is moved behind the patient to allow relaxation of the scapular muscles. With the assistance of the co-attending doctor, the attending doctor reaches into the medial scapular area and lifts both vertically and laterally to separate subscapular adhesions.

THE LUMBAR SPINE:

With the patient supine on the procedure table, the primary physician addressed the patient's lower extremities which were elevated alternatively in a straight leg raising manner to until resistance due to adhesions and/or nociceptive response by the patient. Linear force is used to increase the hip flexion gradually during this maneuver. Simultaneously, the co-attending physician applies a myofascial release technique to the calf and posterior thigh musculature. Each lower extremity was independently bent at the knee and tractioned cephalad in a neutral sagittal plane, lateral oblique cephalad traction, and medial oblique cephalad traction maneuver. The primary physician then approximated the opposite single knee from their position from neutral to medial slightly beyond the elastic barrier of resistance, allowing for a piriformis myofascial release as well. This was repeated with the opposite lower extremity. Following this, a Patrick-Fabre maneuver was performed up to and slightly beyond the elastic barrier of resistance.

PIRIFORMIS BOW-STRING STRETCH:

With the patient in the supine posture and following the adductor stretch, the patient's knee is held slightly past medial and the attending doctor contacts the knee with their hand. The force is applied toward the table with the help of the co-attending doctor and the piriformis muscle is then massaged. The force down the femur into the pelvic basin allows for relaxation of the piriformis muscle across the obturator foramina.

With the co-attending physician stabilizing the pelvis and femoral head, the attending physician extended the right lower extremity in the sagittal plane, and while applying controlled traction radically stretched the para-articular holding elements of the right hip by means of gradually describing an approximately 30-35 degree horizontal arc. The lower extremity was then traction straight caudad and internal rotation was accomplished. Using traction, the lower extremity was gradually stretched into a horizontal arch to approximately 30 degrees. This procedure was then repeated using external rotation to stretch the para-articular holding elements of the hips bilaterally. These procedures were then repeated on the opposite lower extremity.

With the patient's lower extremities kept in hip and knee flexion, the patient's torso was secured by the co-attending doctor and the lumbar fasciae and musculature elongated obliquely to the right of mid-line, in a controlled manner up to and beyond the elastic barrier of resistance. Cavitation was noted. This was repeated on the opposite side.

The patient is then repositioned in the supine posture and the same lateral knee movement is repeated bilaterally only this time there is more of a torsion traction movement up toward the head and then laterally away from the main trunk thereby stretching the lumbar holding elements of the spinal motion units. This posture is proving to

show potential disc decompression as evidenced by pre and post MRI studies that have been completed for research purposes.

With the use of under sheets, the patient was carefully placed in the side lying decubitus position and positioned so that the lumbar spine overlay the kidney plate to the point where the lumbar spine attained the horizontal and was de-rotated to avoid facet imbrications.

ILIOPSOAS STRETCH:

With the patient in the side lying position, the upper leg is bent at the knee and distracted in a horizontal manner to stretch the iliopsoas muscle. The leg is then extended more caudad at a 30 degree angle to stretch the TFL.

The patient's body was stabilized by the first assistant. The knee and hip of the upper leg were flexed and the lower leg stabilized in the extended position by the co-attending doctor. Segmental localization of the appropriate lumbar motion-units was made by the attending physician and the elastic barrier of resistance found. A low velocity impulse thrust was applied achieving cavitation. This procedure was then repeated for the sacroiliac joint. The posterior superior iliac spine and lumbar spine was then adjusted on the opposite side with the patient in the same position as above.

The patient was then repositioned supine by means of the under sheets. With appropriate assistance, the patient was transferred from the procedure table to the gurney and was returned to the recovery room, where appropriate monitoring equipment was utilized to monitor vital signs. The IV was maintained up to the point where the patient was fully alert and stable. The patient was then transferred to a sitting recovery position and given fluids and a light snack. Following this, the patient was discharged with appropriate home instructions.

COMPLICATIONS:

The patient tolerated the procedure well with no untoward incident or complication.

SUMMARY:

The patient tolerated the procedure well and without complications and recovered from the general anesthesia without difficulty.

SUMMARY:

The patient underwent MUA of the axial spine and extremities. The patient tolerated the procedure well; there were no intra-operative or post-operative complications. The patient was able to achieve increased motion post MUA without significant muscle guarding. With the improvement of range of motion, it is medically reasonable to opine that this patient's fibro-adhesive conditions were significantly impacted, increasing the potential for appropriate neuromuscular re-education of affected myofascial structures and before having re-establishment of collagen deposition during the healing phase.

PATIENT INSTRUCTIONS:

The patient will receive post MUA therapy in the doctor's office or P.T. suite to include heating the area of involvement; stretching of the involved areas just as they were stretched during the MUA procedure; followed by interferential in a hertz range of 80-120 and 0-10 with cryotherapy for a duration of no longer than 20 minutes. This will be completed each day after the MUA procedure.

PROGNOSIS:

The patient underwent post MUA examination and considering the patient's overall improvement in function and diminishing pain, it is opined, absent further injury, that the patient's prognosis is considered to be good. The patient will continue with the next procedure based on the improvement noticed during the post examination and in keeping with the recommendations of the serial pattern of MUAs as per standing orders. This follows standards and protocols as established by the National Academy of MUA Physicians. The patient has been instructed that periodic exacerbations or remissions may be experienced. These may be adequately managed by means of palliative care and with the recommended post MUA therapy.

Recommendations For Pre and Post Instructions to The MUA Patient

Pre MUA Instructions:

The patient should get a good nights sleep; the patient needs to be NPO 8-12 hours before the procedure due to the administration of anesthesia; the patient should not eat a heavy meal the night before the procedure is completed the following day; medications that are taken normally are usually taken with a sip of water the morning of the procedure (these recommendations are determined by the anesthesiologist in charge of the procedure, i.e for hypertension etc.); the patient must have undergone a medical clearance for anesthesia by an MD or a DO who is familiar with the procedure that is being performed so that an accurate opinion of the patient tolerating the anesthesia is obtained prior to undergoing MUA; the patient **must** have transportation other than themselves from the facility where the procedure is being performed back to their home. No one will be allowed to leave the facility without proper transportation; the patient should be out of work the days that the procedure is being administered. This procedure involves the administration of an anesthesia and the patient should not be signing anything important, making decisions, nor driving any vehicle while they are under the effects of the anesthesia which could affect them most of the day of the procedure.

Post MUA Instructions:

The post MUA instructions are based on what the treating physician wants the patient to do. However, the generalized post MUA instructions consist of returning to a semi-normal to normal diet. By this we mean that on the days of the MUA when a second or third MUA are completed the next day we recommend that a light diet be followed. Once the MUAs have been completed then the patient can return to their normal diet with recommendations from their treating physician. On the days of the procedure, we recommend that the patient be seen at the treating doctor's office later that same day if possible. With late afternoon MUA procedures being completed this is not practical, but when procedures are completed in the morning the patient should return to the office in the afternoon for post MUA care same day. We recommend that ice be used by the patient, and that they follow the instructions of the anesthesiologist, or medical treating doctor as far as post MUA medications. The patient should rest the days of the procedures, and should not be doing anything strenuous. Doing strenuous exercise or movements could cause harm to the patients until given permission to do these types of activities by their treating physician. Again, if the patient is going to undergo the next in a series of MUAs, the patient should be NPO 8-12 hours before the next days MUAs. Over the years we have not had any lingering effects from anesthesia when multiple MUAs are completed on three successive days.

Recommendations For Post MUA Therapy and Rehabilitation

The treating physician is ultimately responsible for the post MUA care. Our recommendation is that since we are attempting, and in most cases accomplishing the altering of adhesions (fibroblastic proliferative collagen tissue) from reforming in and about the joints and holding elements, that continued regular stretching should be started immediately after the MUAs. We recommend that if possible these stretches be the same as during the MUA procedure, and that

they be performed on the same day as the MUA with no manual adjustive therapy. Once the final MUA is completed, we recommend continuing with the stretching process that has already begun, but that now the adjustive techniques also be added. This process should ideally be performed on a daily basis for 7-10 days following the MUA procedures. We then recommend 2 weeks of pre-rehabilitation which would involve the beginning of continued movement with slight resistive strengthening. This is still not the time for conditioning and strengthening, but a time for the patient to start rebuilding the strength that was lost from injury, and from the process of the MUA procedure where weakening occurs as part of the corrections that take place as a result of performing this procedure. This is then followed by between 4 and 6 weeks of formal rehabilitation. It is this part of the post recovery phase of MUA where the patient claims his or her recovery and strengthens the body to return to their normal pre-injury physical capacity and activities of daily living. We recommend circuit training which not only helps the patient regain strength, but is also enjoyable to accomplish. Encouragement for re-strengthening should be foremost on the treating physicians mind at this point so that the patient will want to continue with their fitness program when they are dismissed from formal treatment.



All Things Financial.

Raakhi Phillips
Vice President
Business Banking

December 7, 2012

Ms. Melanie Hill, Executive Director
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Re: Financing for Spinal Health Care Associates, P.C.

Dear Ms. Hill:

We are aware at First Tennessee Bank that Spinal Health Care Associates, P.C. is filing a Certificate of Need application for the establishment of a specialized ambulatory surgical treatment center which will be located next door to Dr. Rock Wooster. I am advised that the total new funds necessary to implement this center will not exceed \$200,000, which includes funds for legal, administrative and consulting, site preparation, construction/renovation, and equipment.

Spinal Health Care Associates, P.C. and Dr. Wooster have been good clients of First Tennessee for some time. Please use this letter as verification that Spinal Health Care Associates, P.C. and Dr. Wooster maintain an average monthly balance sufficient to serve as cash reserves for the implementation of this project

Should you need any additional information do not hesitate to contact me at (901) 681-2582 or rkphillips@ftb.com.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Raakhi Phillips'.

Raakhi Phillips
Vice President
Business Banking

First Tennessee Bank National Association
4385 Poplar Avenue
Memphis, TN 38117
Phone: (901) 681-2582
Fax: (901) 681-2305
rkphillips@ftb.com

Spinal Healthcare Associates PC
Unaudited Financial Statement
Month Ended September 30, 2012

Isley, Curry, & Associates
108 N. Water Street
Suite 200M
Liberty, MO 64068

Spinal Healthcare Associates PC

Balance Sheet

As of September 30, 2012

Sep 30, 12

ASSETS	
Current Assets	
Checking/Savings	93,202.93
First Tennessee Bank 181064157	
Total Checking/Savings	93,202.93
Other Current Assets	
Loan - Coleman	250.00
Deferred Interest	2,393.82
Loan - Edwards	16,000.00
Loan to Shareholder	506,685.39
Total Other Current Assets	525,329.21
Total Current Assets	618,532.14
Fixed Assets	
Leasehold Improvements	149,820.27
Property & Equipment	488,849.93
Accumulated Depreciation	-459,964.00
Total Fixed Assets	178,706.20
TOTAL ASSETS	797,238.34
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	-373.88
Accrued Salaries	
Total Other Current Liabilities	-373.88
Total Current Liabilities	-373.88
Long Term Liabilities	
Line of Credit	19,112.92

Spinal Healthcare Associates PC

Balance Sheet

As of September 30, 2012

	Sep 30, 12
Equipment Note	
Key Equipment	-769.59
Total Equipment Note	-769.59
Total Long Term Liabilities	18,343.33
Total Liabilities	17,969.45
Equity	
Common Stock	100.00
Retained Earnings	681,638.95
Shareholder Distribution	-24,740.00
Net Income	122,269.94
Total Equity	779,268.89
TOTAL LIABILITIES & EQUITY	797,238.34

Spinal Healthcare Associates PC
Profit & Loss
September 2012

	Sep 12	Jan - Sep 12
Ordinary Income/Expense		
Income		
Fees Collected	200,485.86	2,018,134.40
Total Income	200,485.86	2,018,134.40
Cost of Goods Sold		
Fee Refunds	0.00	40.00
Total COGS	0.00	40.00
Gross Profit	200,485.86	2,018,094.40
Expense		
Start Up Cost Surgical Center	0.00	20,000.00
Advertising & Marketing	3,885.00	68,844.89
Automobile Expense	0.00	1,090.30
Bank Service Charges	0.00	191.31
Billing Expense	0.00	844.75
Collection Expenses	0.00	1,072.72
Credit Card Fees	487.11	1,010.49
Depreciation	3,255.02	29,295.18
Donations	150.00	200.00
Dues & Memberships	374.50	1,454.48
Equipment Maintenance	0.00	5,274.60
Equipment Rentals	1,621.67	14,082.85
General Maintenance	132.00	2,927.49
Housekeeping/Cleaning	0.00	260.00
Insurance		
Business	685.00	1,285.00
Life	182.25	546.75
Malpractice	438.07	5,035.73
Insurance - Other	438.50	6,112.16
Total Insurance	1,743.82	12,979.64
Interest	0.00	420.89
Licenses	285.00	722.00
Office General Expense	48,173.55	411,485.43
Outside Contractors	21,439.32	146,753.34
Patient Refunds	0.00	816.44

Spinal Healthcare Associates PC

Profit & Loss

September 2012

	Sep 12	Jan - Sep 12
Payroll Expenses		
Federal Unemployment Taxes	0.00	569.21
	4,680.82	76,885.23
Total Payroll Expenses	4,680.82	77,454.44
Professional Services	427.16	6,671.82
Property Taxes	0.00	55,297.48
Rent & Leases	35,251.07	182,259.63
Salaries		
Office Asst/Nurses	42,410.29	754,485.27
Owner/Stockholder	7,500.00	12,500.00
Total Salaries	49,910.29	766,985.27
Security Service	0.00	519.03
Seminars	0.00	380.43
Supplies		
Computer Supplies	0.00	813.49
General Admin.	661.81	10,022.30
Medical	579.15	33,946.73
Supplies - Other	322.31	2,079.75
Total Supplies	1,563.27	46,862.27
Taxes		
Real Estate Taxes	0.00	4,670.00
Taxes - Other	1,360.00	1,360.00
Total Taxes	1,360.00	6,030.00
Telephone expenses	464.49	11,217.78
Utilities		
Other	371.24	3,158.29
Waste Disposal	129.80	1,136.78
Utilities - Other	2,097.33	18,124.44
Total Utilities	2,598.37	22,419.51
Total Expense	177,802.46	1,895,824.46
Net Ordinary Income	22,683.40	122,269.94

Spinal Healthcare Associates PC

Profit & Loss

September 2012

	Sep 12	Jan - Sep 12
Net Income	22,683.40	122,269.94

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Spinal Healthcare Associates PC
Reconciliation Detail
First Tennessee Bank 181064157, Period Ending 09/30/2012

Type	Date	Num	Name	Clr	Amount	Balance
Beginning Balance						120,333.40
Cleared Transactions						
Checks and Payments - 65 items						
Check	8/7/2012	7284	Brenda Bailey	X	-380.43	-380.43
Check	8/21/2012	7306	Galatek	X	-364.92	-745.35
Check	8/28/2012	7319	Smith & Nephew	X	-7,500.00	-8,245.35
Check	8/28/2012	7317	Briggs	X	-1,312.00	-9,557.35
Check	8/28/2012	7315	Group Financial	X	-818.29	-10,375.64
Check	8/28/2012	7316	Discover	X	-483.06	-10,858.70
Check	8/28/2012	7318	AFLAC	X	-440.10	-11,298.80
Check	8/28/2012	7314	Carl Hayes	X	-285.00	-11,583.80
Check	8/28/2012	7320	Isley, Curry and As...	X	-150.00	-11,733.80
Check	8/30/2012	7322	Dr. Jason Coleman	X	-5,000.00	-16,733.80
Check	8/30/2012	7326	WHBQ	X	-2,940.00	-19,673.80
Check	8/30/2012	7323	Dr. Jeff Becker	X	-2,166.66	-21,840.46
Check	8/30/2012	7325	WPTY	X	-1,110.00	-22,950.46
Check	8/30/2012	7327	Tennessee Secreta...	X	-20.00	-22,970.46
Check	9/4/2012	ACH	First Tennessee Bank	X	-487.11	-23,457.57
Check	9/4/2012	7329	Carl Hayes	X	-450.00	-23,907.57
Check	9/4/2012	ACH	TRH	X	-438.50	-24,346.07
Check	9/4/2012	ACH	Premier Finance	X	-438.07	-24,784.14
Check	9/4/2012	7334	TriState Office Sup...	X	-384.56	-25,168.70
Check	9/4/2012	7336	comcast	X	-371.24	-25,539.94
Check	9/4/2012	7332	Stericycle	X	-322.31	-25,862.25
Check	9/4/2012	7331	Novacopy	X	-320.27	-26,182.52
Check	9/4/2012	7333	Dept of Health	X	-285.00	-26,467.52
Check	9/4/2012	7335	michael thatcher	X	-240.00	-26,707.52
Check	9/4/2012	7330	Pacific Life	X	-182.25	-26,889.77
Check	9/4/2012	7337	Waste Connections...	X	-129.80	-27,019.57
Check	9/5/2012	7338	Dr. Tim De Roos	X	-3,450.00	-30,469.57
Check	9/5/2012	7339	Tennessee Dept of ...	X	-1,360.00	-31,829.57
Check	9/5/2012	ACH	IMATRIX	X	-255.00	-32,084.57
Check	9/6/2012	7340	WLMT	X	-3,745.00	-35,829.57
Check	9/6/2012	7341	Carl Hayes	X	-600.00	-36,429.57
Check	9/7/2012	ACH	ADP	X	-96.76	-36,526.33
Check	9/10/2012	7342	PSS	X	-4,445.97	-40,972.30
Check	9/10/2012	7343	cintas	X	-92.86	-41,065.16
Check	9/10/2012	7345	Kevin Richardson	X	-50.00	-41,115.16
Check	9/11/2012	7348	Rock Wooster	X	-10,000.00	-51,115.16
Check	9/11/2012	7349	Dr. Jeff Becker	X	-2,166.66	-53,281.82
Check	9/11/2012	7346	Cash	X	-300.00	-53,581.82
Check	9/11/2012	7347	Vault..., Inc	X	-132.00	-53,713.82
Check	9/12/2012	7350	AT&T	X	-464.49	-54,178.31
Check	9/14/2012	ACH	Payroll	X	-41,697.77	-95,876.08
Check	9/14/2012	ACH	IRS	X	-11,362.91	-107,238.99
Check	9/14/2012	ACH	IRS	X	-2,718.38	-109,957.37
Check	9/14/2012	7352	Sams	X	-374.50	-110,331.87
Check	9/14/2012	7353	Rhondi Edwards	X	-196.29	-110,528.16
Check	9/17/2012	ACH	First Tennessee Bank	X	-15,251.07	-125,779.23
Check	9/17/2012	ACH	First Tennessee Bank	X	-3,007.37	-128,786.60
Check	9/17/2012	ACH	First Tennessee Bank	X	-2,328.00	-131,114.60
Check	9/17/2012	7354	MLGW	X	-2,097.33	-133,211.93
Check	9/17/2012	7355	Endeon	X	-844.75	-134,056.68
Check	9/18/2012	7357	David Pakowski	X	-150.00	-134,206.68
Check	9/18/2012	7358	catholic diocese	X	-100.00	-134,306.68
Check	9/18/2012	7356	Novacopy	X	-28.18	-134,334.86
Check	9/19/2012	7361	Cardmember Servic...	X	-24,042.39	-158,377.25
Check	9/19/2012	7360	Bank Card Center	X	-7,722.01	-166,099.26
Check	9/19/2012	7362	TriState Office Sup...	X	-934.09	-167,033.35
Check	9/20/2012	7364	Group Financial	X	-818.29	-167,851.64
Check	9/20/2012	7363	CIT	X	-743.85	-168,595.49
Check	9/21/2012	ACH	ADP	X	-105.40	-168,700.89
Check	9/21/2012	ACH	LADCO LEASING	X	-59.53	-168,760.42
Check	9/24/2012	7367	First Tennessee Bank	X	-1,200.00	-169,960.42
Check	9/24/2012	7365	Kevin Richardson	X	-55.00	-170,015.42
Check	9/25/2012	7369	Rock Wooster	X	-10,000.00	-180,015.42

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Spinal Healthcare Associates PC
Reconciliation Detail
First Tennessee Bank 181064157, Period Ending 09/30/2012

Type	Date	Num	Name	Clr	Amount	Balance
Check	9/25/2012	7373	Dr. Jeff Becker	X	-2,166.66	-182,182.08
Check	9/26/2012	7380	Kevin Richardson	X	-150.00	-182,332.08
Total Checks and Payments					-182,332.08	-182,332.08
Deposits and Credits - 1 item						
Deposit	9/30/2012			X	200,485.86	200,485.86
Total Deposits and Credits					200,485.86	200,485.86
Total Cleared Transactions					18,153.78	18,153.78
Cleared Balance					18,153.78	138,487.18
Uncleared Transactions						
Checks and Payments - 72 items						
Check	12/4/2008	4168	Yolanda Cornell		-200.00	-200.00
Check	2/11/2009	4331	Open Air Market		-58.50	-258.50
Check	3/5/2009	4394	Unknown		-65.00	-323.50
Check	3/6/2009	4399	Unknown		-250.00	-573.50
Check	4/15/2009	10223	Payroll		-2,175.57	-2,749.07
Check	4/15/2009	4468	Hope Presbyterian ...		-90.00	-2,839.07
Check	6/15/2009	vch	Payroll		-135.45	-2,974.52
Check	6/30/2009	vch	Payroll		-103.06	-3,077.58
Check	7/15/2009	4750	Jackie Gilbert		-741.50	-3,819.08
Check	8/24/2009	4866	Michael Parsons		-20.00	-3,839.08
Check	8/31/2009		Payroll		-953.36	-4,792.44
Check	8/31/2009	4888	Lisa Justin		-26.94	-4,819.38
Check	8/31/2009	10409	Payroll		-11.78	-4,831.16
Check	9/15/2009	MAN...	Payroll		-26.94	-4,858.10
Check	11/2/2009	5060	Protek		-401.62	-5,259.72
Check	11/17/2009	5116	Barbara		-40.00	-5,299.72
Check	12/3/2009	5160	Premier Finance		-601.83	-5,901.55
Check	12/7/2009	5167	Protek		-198.00	-6,099.55
Check	12/14/2009	5215	State Farm Insurance		-3,080.00	-9,179.55
Check	12/14/2009	5174	Dr. Connel		-200.00	-9,379.55
Check	12/15/2009	MC1	Payroll		-101.58	-9,481.13
Check	1/15/2010		Payroll		-626.66	-10,107.79
Check	1/15/2010		Payroll		-435.70	-10,543.49
Check	4/22/2010	5504	Norma Brown		-1,500.00	-12,043.49
Check	9/1/2010	5803	Novacopy		-182.92	-12,226.41
Check	10/15/2010	MC	Payroll		-118.85	-12,345.26
Check	10/29/2010	MC	Payroll		-44.32	-12,389.58
Check	11/15/2010	MCA	Payroll		-73.88	-12,463.46
Check	11/17/2010	5973	ACCC		-255.00	-12,718.46
Check	11/18/2010	5977	NRCC		-294.00	-13,012.46
Check	11/29/2010	5986	MDC LLC		-6,000.00	-19,012.46
Check	11/30/2010	MC	Payroll		-55.41	-19,067.87
Check	12/15/2010	MC1	Payroll		-92.35	-19,160.22
Check	12/31/2010	MC2	Payroll		-86.26	-19,246.48
Check	1/31/2011	6086	Payroll		-5.43	-19,251.91
Check	3/4/2011	6206	Great Home School		-450.00	-19,701.91
Check	3/10/2011	6223	Lamberts		-161.29	-19,863.20
Check	3/21/2011	6247	Deluxe Business		-27.29	-19,890.49
Check	4/19/2011	6319	Lamberts		-631.97	-20,522.46
Check	6/7/2011	6418	Cordova		-90.00	-20,612.46
Check	8/5/2011	6545	Fox 13		-2,210.00	-22,822.46
Check	8/11/2011	6567	Davon White		-2.38	-22,824.84
Check	9/14/2011	6635	JERRY ROBINSON		-20.00	-22,844.84
Check	11/8/2011	6746	MidSouth Media Gr...		-10.00	-22,854.84
Check	12/5/2011	6811	AFLAC		-359.86	-23,214.70
Check	12/19/2011	6849	Lamberts		-90.51	-23,305.21
Check	12/29/2011	6870	wafil pro		-20.53	-23,325.74
Check	1/16/2012	6898	Lamberts		-72.25	-23,397.99
Check	4/5/2012	7061	Lamberts		-79.43	-23,477.42
Check	4/25/2012	7094	Jennifer Rocconi		-10.40	-23,487.82
Check	5/18/2012	7121	Delta Medical		-700.00	-24,187.82
Check	8/21/2012	7302	Tennessee Dept of ...		-78.00	-24,265.82
Check	9/13/2012	7351	kylie briley		-109.29	-24,375.11
Check	9/19/2012	7359	Arlington Middle Sc...		-50.00	-24,425.11

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Spinal Healthcare Associates PC
Reconciliation Detail
First Tennessee Bank 181064157, Period Ending 09/30/2012

Type	Date	Num	Name	Clr	Amount	Balance
Check	9/24/2012	7366	Discover		-1,767.48	-26,192.59
Check	9/25/2012	7374	Dr. Jason Coleman		-5,000.00	-31,192.59
Check	9/25/2012	7370	Briggs		-1,049.60	-32,242.19
Check	9/25/2012	7372	Keithly Enterprises		-579.15	-32,821.34
Check	9/25/2012	7368	Purchase Power		-392.09	-33,213.43
Check	9/25/2012	7375	shred it		-214.50	-33,427.93
Check	9/25/2012	7371	Bartlett Landscape		-40.00	-33,467.93
Check	9/26/2012	7377	Smith & Nephew		-3,750.00	-37,217.93
Check	9/26/2012	7376	Hartford		-685.00	-37,902.93
Check	9/26/2012	7379	Arlington Middle Sc...		-100.00	-38,002.93
Check	9/26/2012	7378	Bartlett Landscape		-35.00	-38,037.93
Check	9/27/2012	7381	Sams		-315.52	-38,353.45
Check	9/27/2012	7382	Pitney Bowes		-174.80	-38,528.25
Check	9/27/2012	7383	Isley, Curry and As...		-150.00	-38,678.25
Check	9/28/2012	7384	Dr. Jeff Becker		-5,416.00	-44,094.25
Check	9/28/2012	7387	Dr. Crawford		-1,000.00	-45,094.25
Check	9/28/2012	7386	lakeside behaloral		-150.00	-45,244.25
Check	9/28/2012	7385	ces pta		-40.00	-45,284.25
Total Checks and Payments					-45,284.25	-45,284.25
Total Uncleared Transactions					-45,284.25	-45,284.25
Register Balance as of 09/30/2012					-27,130.47	93,202.93
Ending Balance					-27,130.47	93,202.93

Spinal Healthcare Associates PC General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
First Tennessee Bank 181064157									
Check	9/4/2012	ACH		Premier Finance		Malpractice		438.07	73,097.12
Check	9/4/2012	ACH		TRH		Insurance		438.50	72,659.05
Check	9/4/2012	ACH		First Tennessee Bank		Credit Card F...		487.11	72,220.55
Check	9/4/2012	7329		Carl Hayes		Office Genera...		450.00	71,733.44
Check	9/4/2012	7330		Pacific Life		Life		182.25	71,283.44
Check	9/4/2012	7331		Novacopy		Office Genera...		320.27	71,101.19
Check	9/4/2012	7332		Stericycle		Supplies		322.31	70,780.92
Check	9/4/2012	7333		Dept of Health		Licenses		285.00	70,458.61
Check	9/4/2012	7334		TriState Office Su...		Office Genera...		384.56	70,173.61
Check	9/4/2012	7335		michael thatcher		Outside Contr...		240.00	69,789.05
Check	9/4/2012	7336		comcast		Other		371.24	69,549.05
Check	9/4/2012	7337		Waste Connections ...		Waste Disposal		129.80	69,177.81
Check	9/5/2012	ACH		IMATRIX		Office Genera...		255.00	69,048.01
Check	9/5/2012	7338		Dr. Tim De Roos		Outside Contr...		3,450.00	68,793.01
Check	9/5/2012	7339		Tennessee Dept of ...		Taxes		1,360.00	65,343.01
Check	9/6/2012	7340		WLMAT		Advertising & ...		3,745.00	63,983.01
Check	9/6/2012	7341		Carl Hayes		Office Genera...		600.00	60,238.01
Check	9/7/2012	ACH		ADP		Office Genera...		96.76	59,638.01
Check	9/10/2012	7342		PSS		Professional S...		4,445.97	59,541.25
Check	9/10/2012	7343		cintas		Office Genera...		92.86	55,095.28
Check	9/10/2012	7345		Kevin Richardson		Office Genera...		50.00	55,002.42
Check	9/11/2012	7346		Cash		Office Genera...		300.00	54,952.42
Check	9/11/2012	7347		Vault ..., Inc		Office Maint...		132.00	54,652.42
Check	9/11/2012	7348		Rock Wooster		Rent & Leases		10,000.00	54,520.42
Check	9/11/2012	7349		Dr. Jeff Becker		Outside Contr...		2,166.66	44,520.42
Check	9/12/2012	7350		AT&T		Telephone exp...		464.49	42,353.76
Check	9/13/2012	7351		Kylie Briley		Accrued Salar...		109.29	41,889.27
Check	9/14/2012	ACH		IRS		Payroll Taxes ...		2,718.38	41,779.98
Check	9/14/2012	ACH		IRS		Payroll Taxes ...		11,362.91	39,061.60
Check	9/14/2012	ACH		Payroll		Accrued Salar...		41,697.77	27,698.69
Check	9/14/2012	7352		Sams		Dues & Memb...		374.50	-13,999.08
Check	9/14/2012	7353		Rhondi Edwards		General Admin.		196.29	-14,373.58
Check	9/17/2012	ACH		First Tennessee Bank		Line of Credit		2,328.00	-14,569.87
Check	9/17/2012	ACH		First Tennessee Bank		Line of Credit		3,007.37	-16,897.87
Check	9/17/2012	ACH		First Tennessee Bank		Rent & Leases		15,251.07	-19,905.24
Check	9/17/2012	7354		MLGW		Utilities		2,097.33	-35,156.31
Check	9/17/2012	7355		Endeavor		Office Genera...		844.75	-37,253.64
Check	9/18/2012	7356		Novacopy		Office Genera...		28.18	-38,098.39
									-38,126.57

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Check	9/18/2012	7357		David Pakowski		General Admin.		150.00	-38,276.57
Check	9/18/2012	7358		catholic diocese		Advertising & ...		100.00	-38,376.57
Check	9/19/2012	7359		Arlington Middle Sc...		Donations		50.00	-38,426.57
Check	9/19/2012	7360		Bank Card Center		Office Genera...		7,722.01	-46,148.58
Check	9/19/2012	7361		Cardmember Servic...		Office Genera...		24,042.39	-70,190.97
Check	9/19/2012	7362		TriState Office Su...		Office Genera...		934.09	-71,125.06
Check	9/20/2012	7363		CIT		Equipment Ren...		743.85	-71,868.91
Check	9/20/2012	7364		Group Financial		Equipment Ren...		818.29	-72,687.20
Check	9/21/2012	ACH		LADCO LEASING		Equipment Ren...		59.53	-72,746.73
Check	9/21/2012	ACH		ADP		Professional S...		105.40	-72,852.13
Check	9/24/2012	7365		Kevin Richardson		Office Genera...		55.00	-72,907.13
Check	9/24/2012	7366		Discover		Office Genera...		1,767.48	-74,674.61
Check	9/24/2012	7367		First Tennessee Bank		Line of Credit		1,200.00	-75,874.61
Check	9/25/2012	7368		Purchase Power		Office Genera...		392.09	-76,266.70
Check	9/25/2012	7369		Rock Wooster		Rent & Leases		10,000.00	-86,266.70
Check	9/25/2012	7370		Briggs		Office Genera...		1,049.60	-87,316.30
Check	9/25/2012	7371		Bartlett Landscape		Professional S...		40.00	-87,356.30
Check	9/25/2012	7372		Keithly Enterprises		Medical		579.15	-87,935.45
Check	9/25/2012	7373		Dr. Jeff Becker		Outside Contr ...		2,166.66	-90,102.11
Check	9/25/2012	7374		Dr. Jason Coleman		Outside Contr ...		5,000.00	-95,102.11
Check	9/25/2012	7375		shred it		Office Genera...		214.50	-95,316.61
Check	9/26/2012	7376		Hartford		Business		685.00	-96,001.61
Check	9/26/2012	7377		Smith & Nephew		Office Genera...		3,750.00	-99,751.61
Check	9/26/2012	7378		Bartlett Landscape		Professional S...		35.00	-99,786.61
Check	9/26/2012	7379		Arlington Middle Sc...		Donations		100.00	-99,886.61
Check	9/26/2012	7380		Kevin Richardson		Office Genera...		150.00	-100,036.61
Check	9/27/2012	7381		Sams		General Admin.		315.52	-100,352.13
Check	9/27/2012	7382		Pitney Bowes		Office Genera...		174.80	-100,526.93
Check	9/27/2012	7383		Isley, Curry and As...		Professional S...		150.00	-100,676.93
Check	9/28/2012	7384		Dr. Jeff Becker		Outside Contr ...		5,416.00	-106,092.93
Check	9/28/2012	7385		ces pta		Advertising & ...		40.00	-106,132.93
Check	9/28/2012	7386		lakeside behavioral		Office Genera...		150.00	-106,282.93
Check	9/28/2012	7387		Dr. Crawford		Outside Contr ...		1,000.00	-107,282.93
Deposit	9/30/2012				Deposit	Fees Collected	200,485.86		93,202.93
Total First Tennessee Bank 181064157							200,485.86	180,380.05	93,202.93
First Tennessee Bank 170425788									0.00
Total First Tennessee Bank 170425788									0.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Loan - Coleman									250.00
Total Loan - Coleman									250.00
Employee Advance									0.00
Total Employee Advance									0.00
Due From Vendor									0.00
Total Due From Vendor									0.00
Deferred Interest									2,393.82
Total Deferred Interest									2,393.82
Due From Pyramid Management									0.00
Total Due From Pyramid Management									0.00
Due From Shareholder									0.00
Total Due From Shareholder									0.00
Loan - Edwards									16,000.00
Total Loan - Edwards									16,000.00
Loan to Shareholder									506,685.39
Total Loan to Shareholder									506,685.39
Prepaid State Taxes									0.00
Total Prepaid State Taxes									0.00
Tax Refunds Receivable									0.00
Total Tax Refunds Receivable									0.00
Leasehold Improvements									149,820.27
Total Leasehold Improvements									149,820.27
Property & Equipment									488,849.93
Total Property & Equipment									488,849.93

Spinal Healthcare Associates PC
General Ledger
As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Accumulated Depreciation									
General Journal	9/30/2012	153	*			Depreciation		3,255.02	-456,708.98
Total Accumulated Depreciation							0.00	3,255.02	-459,964.00
Suspense									0.00
Total Suspense									0.00
Patient/Client Records									0.00
Total Patient/Client Records									0.00
Accounts Payable									0.00
Total Accounts Payable									0.00
Accrued Salaries									1,076.64
Check	9/13/2012	7351		Kylie Briley		First Tenness...	109.29		1,185.93
Check	9/14/2012	ACH		Payroll		First Tenness...	41,697.77		42,883.70
General Journal	9/30/2012	154	*			Owner/Stock...		42,509.82	373.88
Total Accrued Salaries							41,807.06	42,509.82	373.88
Accrued State Tax									0.00
Total Accrued State Tax									0.00
Accrued State Taxes									0.00
Total Accrued State Taxes									0.00
Current Liability of Debt									0.00
Total Current Liability of Debt									0.00
Due to Pyramid Management									0.00
Total Due to Pyramid Management									0.00
Payroll Liabilities									0.00
Total Payroll Liabilities									0.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Payroll Taxes Due									
Check	9/14/2012	ACH		IRS		First Tennes...	2,718.38		0.00
Check	9/14/2012	ACH		IRS		First Tennes...	11,362.91		2,718.38
General Journal	9/30/2012	154	*			Owner/Stock...		14,081.29	14,081.29
Total Payroll Taxes Due							14,081.29	14,081.29	0.00
Retirement Plans									0.00
Total Retirement Plans									0.00
Shareholder Loans									0.00
Total Shareholder Loans									0.00
Line of Credit									
Check	9/17/2012	ACH		First Tennessee Bank		First Tennes...	2,328.00		-25,648.29
Check	9/17/2012	ACH		First Tennessee Bank		First Tennes...	3,007.37		-23,320.29
Check	9/24/2012	7367		First Tennessee Bank		First Tennes...	1,200.00		-20,312.92
Total Line of Credit							6,535.37	0.00	-19,112.92
Building Note									0.00
Less Current Liability of Debt									0.00
Total Less Current Liability of Debt									0.00
Building Note - Other									0.00
Total Building Note - Other									0.00
Total Building Note									0.00
Equipment Note									769.59
Key Equipment									769.59
Total Key Equipment									769.59
Less Current Liability of Debt									0.00
Total Less Current Liability of Debt									0.00
Equipment Note - Other									0.00
Total Equipment Note - Other									0.00
Total Equipment Note									769.59

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Note Payable									0.00
Total Note Payable									0.00
Common Stock									-100.00
Total Common Stock									-100.00
Open Bal Equity									0.00
Total Open Bal Equity									0.00
Retained Earnings									-681,638.95
Total Retained Earnings									-681,638.95
Shareholder Distribution									24,740.00
Total Shareholder Distribution									24,740.00
Other Income									0.00
Total Other Income									0.00
Bad Debt Recovery									0.00
Total Bad Debt Recovery									0.00
Copayments									0.00
Total Copayments									0.00
Fees Collected									-1,817,648.54
Dental Record Copy Charges									0.00
Total Dental Record Copy Charges									0.00
Exam/Consultation									0.00
Total Exam/Consultation									0.00
Lab Fees									0.00
Total Lab Fees									0.00
Preventive Services									0.00
Total Preventive Services									0.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Surgery									0.00
Total Surgery									0.00
Treatments									0.00
Total Treatments									0.00
X-Ray									0.00
Total X-Ray									0.00
Fees Collected - Other									-1,817,648.54
Deposit	9/30/2012				Deposit	First Tenness...		200,485.86	-2,018,134.40
Total Fees Collected - Other							0.00	200,485.86	-2,018,134.40
Total Fees Collected							0.00	200,485.86	-2,018,134.40
Income from Investments									0.00
Total Income from Investments									0.00
Miscellaneous Income									0.00
Total Miscellaneous Income									0.00
Nonoperating Revenues									0.00
Total Nonoperating Revenues									0.00
Nonoperating Subsidiary Income									0.00
Total Nonoperating Subsidiary Income									0.00
Operating Subsidiary Income									0.00
Total Operating Subsidiary Income									0.00
Research/Clinical Study Income									0.00
Total Research/Clinical Study Income									0.00
Fee Refunds									40.00
Total Fee Refunds									40.00
Start Up Cost Surgical Center									20,000.00
Total Start Up Cost Surgical Center									20,000.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
contributions									0.00
Total contributions									0.00
Penalties									0.00
Total Penalties									0.00
Moving Expense									0.00
Total Moving Expense									0.00
Accounting Services									0.00
Total Accounting Services									0.00
Administrative & Office Expense									0.00
Total Administrative & Office Expense									0.00
Advertising & Marketing									64,959.89
Check	9/6/2012	7340		WLMT			3,745.00		68,704.89
Check	9/18/2012	7358		catholic diocese			100.00		68,804.89
Check	9/28/2012	7385		ces pta			40.00		68,844.89
Total Advertising & Marketing							3,885.00	0.00	68,844.89
Amortization									0.00
Total Amortization									0.00
Answering Service									0.00
Total Answering Service									0.00
Automobile Expense									1,090.30
Total Automobile Expense									1,090.30
Bad Debt Expense									0.00
Total Bad Debt Expense									0.00
Bank Service Charges									191.31
Total Bank Service Charges									191.31
Beeper & Pagers									0.00
Total Beeper & Pagers									0.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Billing Expense									844.75
Total Billing Expense									844.75
Books & Subscriptions									0.00
Total Books & Subscriptions									0.00
Business/Practice Development									0.00
Total Business/Practice Development									0.00
Club Dues									0.00
Total Club Dues									0.00
Collection Expenses									1,072.72
Total Collection Expenses									1,072.72
Computer Software									0.00
Total Computer Software									0.00
Contract Services									0.00
Total Contract Services									0.00
Copying									0.00
Total Copying									0.00
Courier & Overnight Delivery									0.00
Total Courier & Overnight Delivery									0.00
Credit Card Fees									523.38
Check	9/4/2012	ACH		First Tennessee Bank		First Tennesse...	487.11		1,010.49
Total Credit Card Fees							487.11	0.00	1,010.49
Deferred Compensation									0.00
Total Deferred Compensation									0.00
Dental Conference & Event Fees									0.00
Total Dental Conference & Event Fees									0.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Dental Forms									0.00
Total Dental Forms									0.00
Dental Laboratory Expenses									0.00
Total Dental Laboratory Expenses									0.00
Depreciation									26,040.16
Capital Leases									0.00
Total Capital Leases									0.00
Computer									0.00
Total Computer									0.00
Equipment									0.00
Total Equipment									0.00
Furniture									0.00
Total Furniture									0.00
Other									0.00
Total Other									0.00
Depreciation - Other									26,040.16
General Journal	9/30/2012	153	*				3,255.02		29,295.18
Total Depreciation - Other							3,255.02	0.00	29,295.18
Total Depreciation							3,255.02	0.00	29,295.18
Distributions & Incentives									0.00
Total Distributions & Incentives									0.00
Donations									50.00
Check	9/19/2012	7359		Arlington Middle Sc...			50.00		100.00
Check	9/26/2012	7379		Arlington Middle Sc...			100.00		200.00
Total Donations							150.00	0.00	200.00
Drugs & Medications									0.00
Total Drugs & Medications									0.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Dues & Memberships									
Check	9/14/2012	7352		Sams		First Tennes...	374.50		1,079.98
Total Dues & Memberships							374.50	0.00	1,454.48
Employee Benefits									
Medical Reimbursement Plan									0.00
Total Medical Reimbursement Plan									0.00
Permanent									0.00
Total Permanent									0.00
Temporary									0.00
Total Temporary									0.00
Employee Benefits - Other									0.00
Total Employee Benefits - Other									0.00
Total Employee Benefits									0.00
Employee Incentives									0.00
Total Employee Incentives									0.00
Employee Relations									0.00
Total Employee Relations									0.00
Equipment Maintenance									5,274.60
Total Equipment Maintenance									5,274.60
Equipment Rentals									12,461.18
Check	9/20/2012	7363		CIT		First Tennes...	743.85		13,205.03
Check	9/20/2012	7364		Group Financial		First Tennes...	818.29		14,023.32
Check	9/21/2012	ACH		LADCO LEASING		First Tennes...	59.53		14,082.85
Total Equipment Rentals							1,621.67	0.00	14,082.85
Fines									0.00
Total Fines									0.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
General Maintenance Check	9/11/2012	7347		Vault ..., Inc		First Tennes...	132.00		2,795.49
Total General Maintenance							132.00	0.00	2,927.49
Gifts									0.00
Total Gifts									0.00
Hazardous Waste Removal									0.00
Total Hazardous Waste Removal									0.00
Housekeeping/Cleaning									260.00
Total Housekeeping/Cleaning									260.00
Income Expense									0.00
Total Income Expense									0.00
Insurance									11,235.82
Business Check	9/26/2012	7376		Hartford		First Tennes...	685.00		600.00
Total Business							685.00	0.00	1,285.00
Dental									0.00
Total Dental									0.00
Disability									0.00
Total Disability									0.00
Health									0.00
Total Health									0.00
Life Check	9/4/2012	7330		Pacific Life		First Tennes...	182.25		364.50
Total Life							182.25	0.00	546.75
Malpractice Check	9/4/2012	ACH		Premier Finance		First Tennes...	438.07		4,597.66
Total Malpractice							438.07	0.00	5,035.73

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Other									0.00
Total Other									0.00
Worker's Comp									0.00
Total Worker's Comp									0.00
Insurance - Other									5,673.66
Check	9/4/2012	ACH		TRH		First Tennes...	438.50		6,112.16
Total Insurance - Other							438.50	0.00	6,112.16
Total Insurance							1,743.82	0.00	12,979.64
Insurance Write-offs									0.00
Total Insurance Write-offs									0.00
Interest									420.89
Total Interest									420.89
Investment Expenses									0.00
Total Investment Expenses									0.00
Lab Fees									0.00
Total Lab Fees									0.00
Legal Services									0.00
Total Legal Services									0.00
Licenses									437.00
Check	9/4/2012	7333		Dept of Health		First Tennes...	285.00		722.00
Total Licenses							285.00	0.00	722.00
Management Company Fees									0.00
Total Management Company Fees									0.00
Meals & Entertainment									0.00
Total Meals & Entertainment									0.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Merchant Fees									
Total Merchant Fees									0.00
Nonoperating Expenses									
Total Nonoperating Expenses									0.00
Office General Expense									
Check	9/4/2012	7329		Carl Hayes		First Tenness...	450.00		363,311.88
Check	9/4/2012	7331		Novacopy		First Tenness...	320.27		363,761.88
Check	9/4/2012	7334		TriState Office Su...		First Tenness...	384.56		364,082.15
Check	9/5/2012	ACH		IMA TRIX		First Tenness...	255.00		364,466.71
Check	9/6/2012	7341		Carl Hayes		First Tenness...	600.00		364,721.71
Check	9/10/2012	7342		PSS		First Tenness...	4,445.97		365,321.71
Check	9/10/2012	7343		cintas		First Tenness...	92.86		369,767.68
Check	9/10/2012	7345		Kevin Richardson		First Tenness...	50.00		369,860.54
Check	9/11/2012	7346		Cash		First Tenness...	300.00		369,910.54
Check	9/17/2012	7355		Endeon		First Tenness...	844.75		370,210.54
Check	9/18/2012	7356		Novacopy		First Tenness...	28.18		371,055.29
Check	9/19/2012	7360		Bank Card Center		First Tenness...	7,722.01		371,083.47
Check	9/19/2012	7361		Cardmember Servic...		First Tenness...	24,042.39		378,805.48
Check	9/19/2012	7362		TriState Office Su...		First Tenness...	934.09		402,847.87
Check	9/24/2012	7365		Kevin Richardson		First Tenness...	55.00		403,781.96
Check	9/24/2012	7366		Discover		First Tenness...	1,767.48		403,836.96
Check	9/25/2012	7368		Purchase Power		First Tenness...	392.09		405,604.44
Check	9/25/2012	7370		Briggs		First Tenness...	1,049.60		405,996.53
Check	9/25/2012	7375		shred it		First Tenness...	214.50		407,046.13
Check	9/26/2012	7377		Smith & Nephew		First Tenness...	3,750.00		407,260.63
Check	9/26/2012	7380		Kevin Richardson		First Tenness...	150.00		411,010.63
Check	9/27/2012	7382		Pitney Bowes		First Tenness...	174.80		411,160.63
Check	9/28/2012	7386		Lakeside behavioral		First Tenness...	150.00		411,335.43
Total Office General Expense							48,173.55	0.00	411,485.43

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Outside Contractors									
Check	9/4/2012	7335		michael thatcher		First Tenness...	240.00		125,314.02
Check	9/5/2012	7338		Dr. Tim De Roos		First Tenness...	3,450.00		125,554.02
Check	9/11/2012	7349		Dr. Jeff Becker		First Tenness...	2,166.66		129,004.02
Check	9/25/2012	7373		Dr. Jeff Becker		First Tenness...	2,166.66		131,170.68
Check	9/25/2012	7374		Dr. Jason Coleman		First Tenness...	5,000.00		133,337.34
Check	9/25/2012	7384		Dr. Jeff Becker		First Tenness...	5,416.00		138,337.34
Check	9/28/2012	7387		Dr. Crawford		First Tenness...	1,000.00		143,753.34
General Journal	9/30/2012	154	*			Owner/Stock...	2,000.00		144,753.34
Total Outside Contractors							21,439.32	0.00	146,753.34
Parking & Tolls									0.00
Total Parking & Tolls									0.00
Patient Education									0.00
Total Patient Education									0.00
Patient Refunds									816.44
Total Patient Refunds									816.44
Payroll Expenses									72,773.62
Federal Unemployment									569.21
Total Federal Unemployment									569.21
FICA/Medicare									0.00
Total FICA/Medicare									0.00
Taxes									72,204.41
General Journal	9/30/2012	154	*			Owner/Stock...	4,680.82		76,885.23
Total Taxes							4,680.82	0.00	76,885.23
State Unemployment									0.00
Total State Unemployment									0.00
Payroll Expenses - Other									0.00
Total Payroll Expenses - Other									0.00
Total Payroll Expenses							4,680.82	0.00	77,454.44

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Pension & Retirement Benefits									0.00
Total Pension & Retirement Benefits									0.00
Pension Administration Expense									0.00
Total Pension Administration Expense									0.00
Photography (X-Ray) Expenses									0.00
Total Photography (X-Ray) Expenses									0.00
Postage									0.00
Total Postage									0.00
Printing									0.00
Total Printing									0.00
Professional Development									0.00
Total Professional Development									0.00
Professional Services									6,244.66
Check	9/7/2012	ACH		ADP		First Tennes...	96.76		6,341.42
Check	9/21/2012	ACH		ADP		First Tennes...	105.40		6,446.82
Check	9/25/2012	7371		Bartlett Landscape		First Tennes...	40.00		6,486.82
Check	9/26/2012	7378		Bartlett Landscape		First Tennes...	35.00		6,521.82
Check	9/27/2012	7383		Isley, Curry and As...		First Tennes...	150.00		6,671.82
Total Professional Services							427.16	0.00	6,671.82
Property Taxes									55,297.48
Total Property Taxes									55,297.48
Recruitment									0.00
Total Recruitment									0.00
Rent & Leases									147,008.56
Check	9/11/2012	7348		Rock Wooster		First Tennes...	10,000.00		157,008.56
Check	9/17/2012	ACH		First Tennessee Bank		First Tennes...	15,251.07		172,259.63
Check	9/25/2012	7369		Rock Wooster		First Tennes...	10,000.00		182,259.63
Total Rent & Leases							35,251.07	0.00	182,259.63

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Returned Items									0.00
Total Returned Items									0.00
Salaries									717,074.98
Commissions									0.00
Total Commissions									0.00
Dental Hygienists									0.00
Total Dental Hygienists									0.00
Non-Owner Doctors									0.00
Total Non-Owner Doctors									0.00
Office Asst/Nurses									712,074.98
General Journal	9/30/2012	154	*				42,410.29		754,485.27
Total Office Asst/Nurses							42,410.29	0.00	754,485.27
Other									0.00
Total Other									0.00
Owner/Stockholder									5,000.00
General Journal	9/30/2012	154	*				7,500.00		12,500.00
Total Owner/Stockholder							7,500.00	0.00	12,500.00
Temporary Employee									0.00
Total Temporary Employee									0.00
Salaries - Other									0.00
Total Salaries - Other									0.00
Total Salaries							49,910.29	0.00	766,985.27
Security									0.00
Total Security									0.00
Security Service									519.03
Total Security Service									519.03

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
Seminars									380.43
Total Seminars									380.43
Severance Plan									0.00
Total Severance Plan									0.00
Supplies									45,299.00
Computer Supplies									813.49
Total Computer Supplies									813.49
General Admin.									9,360.49
Check	9/14/2012	7353		Rhondi Edwards			196.29		9,556.78
Check	9/18/2012	7357		David Pakowski			150.00		9,706.78
Check	9/27/2012	7381		Sams			315.52		10,022.30
Total General Admin.							661.81	0.00	10,022.30
Medical									33,367.58
Check	9/25/2012	7372		Keithly Enterprises			579.15		33,946.73
Total Medical							579.15	0.00	33,946.73
Other									0.00
Total Other									0.00
Supplies - Other									1,757.44
Check	9/4/2012	7332		Stericycle			322.31		2,079.75
Total Supplies - Other							322.31	0.00	2,079.75
Total Supplies							1,563.27	0.00	46,862.27
Taxes									4,670.00
Franchise Taxes									0.00
Total Franchise Taxes									0.00
Real Estate Taxes									4,670.00
Total Real Estate Taxes									4,670.00

Spinal Healthcare Associates PC

General Ledger

As of September 30, 2012

Type	Date	Num	Adj	Name	Memo	Split	Debit	Credit	Balance
X-Ray Disposal									0.00
Total X-Ray Disposal									0.00
Voided Checks									0.00
Total Voided Checks									0.00
No accont									0.00
Total no accont									0.00
TOTAL							440,712.04	440,712.04	0.00

**ASTC Utilization
Service Area 2009**

Attachment C.OD.2

ID#	Facility Name	Pts	OR s	Proc. Rms	Tot. Rms	Proc.	Proc/OR
79293	Memphis Eye and Cataract ASTC	1,637	3	0	3	2,954	985
79295	Memphis Surgery Center	2,492	4	1	5	5,813	1,163
79296	Shea Ear Clinic, PA	4,750	2	0	2	2,571	1,286
79297	Wesberry Surgery Center	40	1	2	3	51	17
79305	Ridge Lake Ambulatory Surgery Center	3,289	3	3	6	5,469	912
79603	Le Bonheur East Surgery Center II, LP	3,135	4	0	4	5,346	1,337
79604	G I Diagnostic and Therapeutic Center	4,014	0	6	6	21,515	3,586
79614	Baptist-EMSC	5,987	6	1	7	5,987	855
79617	Germantown ASTC, LLC	105	1	1	2	217	109
79620	Mays & Schnapp Pain Clinic & Rehab. C	1,873	2	0	2	10,018	5,009
79622	Medical Ctr Endoscopy Group	7,395	0	4	4	8,269	2,067
79628	Radiosurgical Ctr of Memphis	155	0	1	1	155	155
79632	Memphis Gastroenterology Endoscopy C	11,790	0	6	6	14,665	2,444
79633	Midtown Surgery Ctr	1,792	4	0	4	3,424	856
79639	Methodist Surgery Ctr Germantown, LP	5,742	4	1	5	13,026	2,605
79645	Mid-South Gastroenterology Group	6,791	0	3	3	7,009	2,336
79646	North Surgery Ctr, LP	2,565	4	1	5	5,224	1,045
79665	UroCenter	2,023	3	0	3	3,482	1,161
79669	Baptist Germantown Surgery Ctr	4,477	6	1	7	7,816	1,117
79687	The West Clinic, PC	1,294	0	1	1	2,165	2,165
79691	Campbell Surgery Ctr	6,506	4	1	5	6,506	1,301
79693	Wolf River Surgery Ctr	4,848	4	2	6	8,934	1,489
79694	Semmes Murphey Clinic	2,886	3	2	5	4,177	835
79720	Endoscopy Ctr of the Mid-South, LLC	2,001	0	1	1	2,760	2,760
79724	Surgery Ctr at Saint Francis	4,918	4	2	6	9,321	1,554
79725	Eye Care Surgery Ctr of Memphis, LLC	1,018	2	1	3	1,559	520
79728	Southwind Endoscopy Ctr, PLLC	988	0	2	2	1,128	564
79734	Boston Baskin Cancer Group, PLC	872	0	2	2	9,395	4,698
79751	Hamilton Eye Institute Surgery Ctr, LP	2,084	3	2	5	4,100	820
Total		97,467	67	47	114	173,056	1,518

Source: 2009 ASCT, JARs, Schedule D - Availability and Utilization of Services

ASTC Utilization Service Area 2010

ID#	Facility Name	Pts	OR s	Proc. Rms	Tot. Rms	Proc.	Proc/OR
79293	Memphis Eye and Cataract ASTC	1,682	3	0	3	3,027	1,009
79295	Memphis Surgery Center	3,385	4	1	5	3,438	688
79296	Shea Ear Clinic, PA	1,448	2	0	2	1,745	873
79297	Wesberry Surgery Center	740	1	0	1	9,240	9,240
79305	Ridge Lake Ambulatory Surgery Center	3,397	2	3	5	5,568	1,114
79603	Le Bonheur East Surgery Center II, LP	3,453	4	0	4	5,810	1,453
79604	G I Diagnostic and Therapeutic Center	15,830	0	6	6	20,913	3,486
79614	Baptist-EMSC	5,195	6	2	8	11,565	1,446
79617	Germantown ASTC, LLC	113	1	1	2	246	123
79620	Mays & Schnapp Pain Clinic & Rehab. C	1,813	2	0	2	9,991	4,996
79622	Medical Ctr Endoscopy Group	7,394	0	4	4	9,200	2,300
79628	Radiosurgical Ctr of Memphis	174	0	1	1	174	174
79632	Memphis Gastroenterology Endoscopy C	9,302	0	6	6	11,512	1,919
79633	Midtown Surgery Ctr	1,911	4	0	4	3,512	878
79639	Methodist Surgery Ctr Germantown, LP	5,323	4	1	5	12,388	2,478
79645	Mid-South Gastroenterology Group	6,990	1	2	3	7,005	2,335
79646	North Surgery Ctr, LP	2,518	4	1	5	5,135	1,027
79665	UroCenter	2,560	3	0	3	5,614	1,871
79669	Baptist Germantown Surgery Ctr	3,768	6	1	7	7,441	1,063
79687	The West Clinic, PC	2,087	0	3	3	2,143	714
79691	Campbell Surgery Ctr	6,619	4	1	5	15,209	3,042
79693	Wolf River Surgery Ctr	4,650	4	2	6	8,421	1,404
79694	Semmes Murphey Clinic	2,926	3	2	5	4,340	868
79720	Endoscopy Ctr of the Mid-South, LLC	1,733	0	1	1	2,648	2,648
79724	Surgery Ctr at Saint Francis	5,803	4	2	6	5,803	967
79725	Eye Care Surgery Ctr of Memphis, LLC	777	2	1	3	1,271	424
79728	Southwind Endoscopy Ctr, PLLC	1,369	0	2	2	1,384	692
79734	Boston Baskin Cancer Group, PLC	960	0	2	2	10,393	5,197
79751	Hamilton Eye Institute Surgery Ctr, LP	2,262	3	2	5	4,538	908
Total		106,182	67	47	114	189,674	1,664

Source: 2010 ASCT, JARs, Schedule D - Availability and Utilization of Services

**ASTC Utilization
Service Area, 2011**

ID#	Facility Name	Pts	OR s	Proc. Rms	Tot. Rms	Proc.	Proc/OR
79293	Memphis Eye and Cataract ASTC	1,749	3	0	3	2,952	984
79295	Memphis Surgery Center	2,915	4	1	5	6,922	1,384
79296	Shea Ear Clinic, PA	1,715	2	0	2	2,269	1,135
79297	Wesberry Surgery Center	837	1	0	1	837	837
79305	Ridge Lake Ambulatory Surgery Center	3,400	2	3	5	5,890	1,178
79603	Le Bonheur East Surgery Center II, LP	3,168	4	0	4	5,425	1,356
79604	G I Diagnostic and Therapeutic Center	16,023	0	6	6	21,286	3,548
79614	East Memphis Surgery Ctr	5,202	6	2	8	10,910	1,364
79617	Germantown ASTC, LLC	93	1	1	2	204	102
79620	Mays & Schnapp Pain Clinic & Rehab. C	1,889	2	0	2	11,117	5,559
79622	Medical Ctr Endoscopy Group	6,461	0	4	4	6,971	1,743
79628	Radiosurgical Ctr of Memphis	169	0	1	1	169	169
79632	Memphis Gastroenterology Endoscopy C	8,952	0	6	6	11,273	1,879
79633	Midtown Surgery Ctr	1,819	4	0	4	3,455	864
79639	Methodist Surgery Ctr Germantown, LP	5,186	4	1	5	11,502	2,300
79645	Mid-South Gastroenterology Group	6,831	0	3	3	6,581	2,194
79646	North Surgery Ctr, LP	2,621	4	1	5	5,391	1,078
79665	UroCenter	2,630	3	0	3	6,959	2,320
79669	Baptist Germantown Surgery Ctr	3,515	5	0	5	7,470	1,494
79687	The West Clinic, PC	2,436	0	3	3	2,988	996
79691	Campbell Surgery Ctr	7,008	4	1	5	15,127	3,025
79693	Wolf River Surgery Ctr	4,371	4	2	6	8,432	1,405
79694	Semmes Murphey Clinic	3,690	3	2	5	5,882	1,176
79720	Endoscopy Ctr of the Mid-South, LLC	1,642	0	1	1	2,556	2,556
79724	Surgery Ctr at Saint Francis	5,597	4	2	6	9,298	1,550
79725	Eye Care Surgery Ctr of Memphis, LLC	693	2	1	3	1,019	340
79728	Southwind Endoscopy Ctr, PLLC	1,361	0	2	2	1,375	688
79734	BMH Tipton Radiation Therapy	1,120	0	2	2	11,438	5,719
79751	Hamilton Eye Institute Surgery Ctr, LP	2,256	3	2	5	4,936	987
Total		105,349	65	47	112	190,634	1,702

Source: 2010 ASCT, JARs, Schedule D - Availability and Utilization of Services

Average Charges 2011 **Service Area ASTCs***

ID#	Facility Name
79293	Memphis Eye and Cataract ASTC
79295	Memphis Surgery Center
79296	Shea Ear Clinic, PA
79297	Wesberry Surgery Center
79305	Ridge Lake Ambulatory Surgery Center
79603	Le Bonheur East Surgery Center II, LP
79604	G I Diagnostic and Therapeutic Center
79614	East Memphis Surgery Ctr
79617	Germantown ASTC, LLC
79620	Mays & Schnapp Pain Clinic & Rehab. Ctr
79622	Medical Ctr Endoscopy Group
79628	Radiosurgical Ctr of Memphis
79632	Memphis Gastroenterology Endoscopy Ctr
79633	Midtown Surgery Ctr
79639	Methodist Surgery Ctr Germantown, LP
79645	Mid-South Gastroenterology Group
79646	North Surgery Ctr, LP
79665	UroCenter
79669	Baptist Germantown Surgery Ctr
79687	The West Clinic, PC
79691	Campbell Surgery Ctr
79693	Wolf River Surgery Ctr
79694	Semmes Murphey Clinic
79720	Endoscopy Ctr of the Mid-South, LLC
79724	Surgery Ctr at Saint Francis
79725	Eye Care Surgery Ctr of Memphis, LLC
79728	Southwind Endoscopy Ctr, PLLC
79734	BMH Tipton Radiation Therapy
79751	Hamilton Eye Institute Surgery Ctr, LP

Pts	Gross/Pts	Deduct./Pts	Net/Pts
1,749	\$1,695	\$0	\$1,695
2,915	\$6,408	\$5,087	\$1,321
1,715	\$3,386	\$2,301	\$1,085
837	\$1,067	\$0	\$1,067
3,400	\$3,160	\$1,813	\$1,347
3,168	\$3,070	\$1,042	\$2,029
16,023	\$1,713	\$1,055	\$658
5,202	\$6,517	\$3,988	\$2,529
93	\$1,160	\$112	\$1,048
1,889	\$8,540	\$5,940	\$2,600
6,461	\$1,474	\$530	\$945
169	\$34,458	\$20,605	\$13,853
8,952	\$1,559	\$924	\$635
1,819	\$7,359	\$5,443	\$1,916
5,186	\$4,778	\$2,866	\$1,912
6,831	\$861	\$475	\$386
2,621	\$4,897	\$3,124	\$1,773
2,630	\$6,125	\$4,471	\$1,654
3,515	\$5,334	\$3,874	\$1,461
2,436	\$2,790	\$1,894	\$895
7,008	\$5,695	\$2,575	\$3,120
4,371	\$4,329	\$3,080	\$1,249
3,690	\$7,381	\$4,445	\$2,935
1,642	\$1,570	\$1,127	\$443
5,597	\$5,215	\$3,804	\$1,411
693	\$2,318	\$945	\$1,373
1,361	\$1,379	\$878	\$501
1,120	\$6,749	\$4,338	\$2,411
2,256	\$4,599	\$3,048	\$1,551

Proc.	Gross/Proc.	Deduct./Proc.	Net/Proc.
2,952	\$1,004	\$0	\$1,004
6,922	\$2,699	\$2,142	\$556
2,269	\$2,559	\$1,739	\$820
837	\$1,067	\$0	\$1,067
5,890	\$1,824	\$1,046	\$778
5,425	\$1,793	\$608	\$1,185
21,286	\$1,290	\$794	\$495
10,910	\$3,108	\$1,901	\$1,206
204	\$529	\$51	\$478
11,117	\$1,451	\$1,009	\$442
6,971	\$1,367	\$491	\$875
169	\$34,458	\$20,605	\$13,853
11,273	\$1,238	\$734	\$505
3,455	\$3,874	\$2,866	\$1,009
11,502	\$2,154	\$1,292	\$862
6,581	\$894	\$493	\$401
5,391	\$2,381	\$1,519	\$862
6,959	\$2,315	\$1,690	\$625
7,470	\$2,510	\$1,823	\$687
2,988	\$2,274	\$1,544	\$730
15,127	\$2,638	\$1,193	\$1,445
8,432	\$2,244	\$1,597	\$648
5,882	\$4,630	\$2,789	\$1,841
2,556	\$1,009	\$724	\$285
9,298	\$3,139	\$2,290	\$850
1,019	\$1,577	\$643	\$934
1,375	\$1,365	\$869	\$496
11,438	\$661	\$425	\$236
4,936	\$2,102	\$1,393	\$709

Source: 2011 JARs, Schedule D & F
 * There are no ASTCs in Fayette or Tipton Counties

Average Patient Charges
Service Area 2010-2011 Hospitals

2010

ID #	Hospitals	Co.	Avg. Gross	Avg. Deduct.	Avg. Net
24226	Methodist Healthcare	Fayette	\$21,306	\$16,825	\$4,481
79216	Baptist Memorial Hospital	Shelby	\$8,230	\$5,565	\$2,665
79236	Methodist Hospital - Germantown	Shelby	\$10,941	\$7,875	\$3,066
79246	The Regional Medical Center at Memphis	Shelby	\$10,729	\$8,613	\$2,116
79256	Saint Jude Children's Research Hospital	Shelby	\$18,786	\$13,458	\$5,328
79266	Methodist Hospital - South	Shelby	\$10,745	\$8,112	\$2,633
79276	Methodist Healthcare - Memphis Hospitals	Shelby	\$10,735	\$8,001	\$2,734
79296	Methodist Hospital - North	Shelby	\$10,175	\$7,839	\$2,336
79306	Lebonheur Children's Medical Center	Shelby	\$11,630	\$6,953	\$4,677
79326	Three Rivers Hospital	Shelby	\$10,624	\$6,562	\$4,062
79386	Delta Medical Center	Shelby	\$4,658	\$3,428	\$1,230
79396	Saint Francis Hospital	Shelby	\$12,885	\$10,416	\$2,469
79446	Memphis Mental Health Institute	Shelby	\$1,155	\$997	\$158
79456	Lakeside Behavioral Health System	Shelby	\$1,503	\$773	\$730
79476	Community Behavioral Health	Shelby	\$1,326	\$670	\$656
79506	Baptist Memorial Hospital for Women	Shelby	\$4,072	\$2,287	\$1,785
79516	Saint Francis Hospital - Bartlett	Shelby	\$14,371	\$11,682	\$2,689
79756	HealthSouth Rehabilitation Hospital	Shelby	\$2,264	\$1,058	\$1,206
79766	Baptist Rehabilitation - Germantown	Shelby	\$4,371	\$2,695	\$1,676
79776	Baptist Memorial Restorative Care Hospital	Shelby	\$4,758	\$3,491	\$1,267
79786	Select Specialty Hospital - Memphis	Shelby	\$3,961	\$2,328	\$1,633
79796	Methodist Extended Care Hospital, Inc	Shelby	\$2,851	\$1,516	\$1,335
79806	HealthSouth Rehab. Hospital - Memphis N.	Shelby	\$1,807	\$608	\$1,199
84256	Baptist Memorial Hospital	Tipton	\$12,081	\$8,290	\$3,791

2011

ID #	Hospitals	Co.	Avg. Gross	Avg. Deduct.	Avg. Net
24226	Methodist Healthcare	Fayette	\$32,072	\$25,312	\$6,761
79216	Baptist Memorial Hospital	Shelby	\$8,909	\$6,365	\$2,544
79236	Methodist Hospital - Germantown	Shelby	\$11,087	\$7,937	\$3,150
79246	The Regional Medical Center at Memphis	Shelby	\$11,716	\$9,327	\$2,389
79256	Saint Jude Children's Research Hospital	Shelby	\$23,147	\$17,402	\$5,744
79266	Methodist Hospital - South	Shelby	\$11,450	\$8,829	\$2,622
79276	Methodist Healthcare - Memphis Hospitals	Shelby	\$11,548	\$8,666	\$2,881
79296	Methodist Hospital - North	Shelby	\$10,217	\$7,944	\$2,273
79306	Lebonheur Children's Medical Center	Shelby	\$12,686	\$7,672	\$5,014
79326	Three Rivers Hospital	Shelby	\$14,312	\$9,789	\$4,523
79386	Delta Medical Center	Shelby	\$4,275	\$3,019	\$1,256
79396	Saint Francis Hospital	Shelby	\$13,843	\$11,154	\$2,689
79446	Memphis Mental Health Institute	Shelby	\$1,010	\$854	\$156
79456	Lakeside Behavioral Health System	Shelby	\$1,532	\$766	\$766
79476	Community Behavioral Health	Shelby	\$1,341	\$790	\$551
79506	Baptist Memorial Hospital for Women	Shelby	\$4,311	\$2,614	\$1,697
79516	Saint Francis Hospital - Bartlett	Shelby	\$15,093	\$12,252	\$2,841
79756	HealthSouth Rehabilitation Hospital	Shelby	\$2,355	\$1,029	\$1,326
79766	Baptist Rehabilitation - Germantown	Shelby	\$5,391	\$3,055	\$2,336
79776	Baptist Memorial Restorative Care Hospital	Shelby	\$5,541	\$3,997	\$1,545
79786	Select Specialty Hospital - Memphis	Shelby	\$4,110	\$2,543	\$1,567
79796	Methodist Extended Care Hospital, Inc	Shelby	\$3,313	\$1,953	\$1,360
79806	HealthSouth Rehab. Hospital - Memphis N.	Shelby	\$1,848	\$500	\$1,348
84256	Baptist Memorial Hospital	Tipton	\$13,373	\$9,487	\$3,886

Source: 2010 & 2011(Provisional) JARs, Schedule E-Financial Data & Schedule G-Utilization

Hospital Surgery Utilization Service Area 2008-2011

2008

ID #	Hospitals	Co.	ORs	Ded O/P	I/P	O/P	Total	Proc/OR
24226	Methodist Healthcare	Fayette	2	0	130	899	1,029	515
79216	Baptist Memorial Hospital	Shelby	26	0	8,463	6,545	15,008	577
79326	Baptist Memorial Hospital - Collierville	Shelby	6	0	811	1,566	2,377	396
79506	Baptist Memorial Hospital for Women	Shelby	5	0	1,292	1,879	3,171	634
79386	Delta Medical Center	Shelby	8	0	2,344	4,397	6,741	843
79306	Lebonheur Children's Medical Center	Shelby	10	0	3,414	6,980	10,394	1,039
79276	Methodist Healthcare - Memphis Hospitals	Shelby	19	0	5,662	3,351	9,013	474
79236	Methodist Hospital - Germantown	Shelby	12	0	4,204	6,044	10,248	854
79296	Methodist Hospital - North	Shelby	11	0	2,136	1,016	3,152	287
79266	Methodist Hospital - South	Shelby	6	0	1,087	997	2,084	347
79396	Saint Francis Hospital	Shelby	22	0	5,329	3,961	9,290	422
79516	Saint Francis Hospital - Bartlett	Shelby	4	0	2,772	2,216	4,988	1,247
79256	Saint Jude Children's Research Hospital	Shelby	0	0	518	1,046	1,564	0
79246	The Regional Medical Center at Memphis	Shelby	13	0	7,743	1,058	8,801	677
84256	Baptist Memorial Hospital	Tipton	4	0	360	1,266	1,626	407
Total			148	0	46,265	43,221	89,486	605

2009

ID #	Hospitals	Co.	ORs	Ded O/P	I/P	O/P	Total	Proc/OR
24226	Methodist Healthcare	Fayette	2	0	101	599	700	350
79216	Baptist Memorial Hospital	Shelby	26	0	8,687	6,206	14,893	573
79326	Baptist Memorial Hospital - Collierville	Shelby	6	0	1,172	1,755	2,927	488
79506	Baptist Memorial Hospital for Women	Shelby	5	0	1,127	1,880	3,007	601
79386	Delta Medical Center	Shelby	8	0	2,589	4,284	6,873	859
79306	Lebonheur Children's Medical Center	Shelby	10	0	4,149	6,836	10,985	1,099
79276	Methodist Healthcare - Memphis Hospitals	Shelby	13	0	6,178	3,334	9,512	732
79236	Methodist Hospital - Germantown	Shelby	12	0	4,260	5,194	9,454	788
79296	Methodist Hospital - North	Shelby	10	0	2,087	860	2,947	295
79266	Methodist Hospital - South	Shelby	6	0	1,177	1,224	2,401	400
79396	Saint Francis Hospital	Shelby	22	0	3,604	5,541	9,145	416
79516	Saint Francis Hospital - Bartlett	Shelby	4	0	3,364	2,896	6,260	1,565
79256	Saint Jude Children's Research Hospital	Shelby	2	2	442	1,123	1,565	783
79246	The Regional Medical Center at Memphis	Shelby	13	0	8,699	4,490	13,189	1,015
84256	Baptist Memorial Hospital	Tipton	4	0	319	1,255	1,574	394
Total			143	2	47,955	47,477	95,432	667

Hospital Surgery Utilization Service Area 2008-2011

2010

ID #	Hospitals	Co.	ORs	Ded O/P	I/P	O/P	Total	Proc/OR
24226	Methodist Healthcare	Fayette	2	0	62	599	661	331
79216	Baptist Memorial Hospital	Shelby	26	0	8,149	5,790	13,939	536
79326	Baptist Memorial Hospital - Collierville	Shelby	6	0	1,168	1,731	2,899	483
79506	Baptist Memorial Hospital for Women	Shelby	5	0	1,006	1,725	2,731	546
79386	Delta Medical Center	Shelby	8	0	1,969	3,848	5,817	727
79306	Lebonheur Children's Medical Center	Shelby	10	0	5,141	4,762	9,903	990
79276	Methodist Healthcare - Memphis Hospitals	Shelby	13	0	6,328	3,476	9,804	754
79236	Methodist Hospital - Germantown	Shelby	16	0	4,576	5,387	9,963	623
79296	Methodist Hospital - North	Shelby	10	0	2,055	991	3,046	305
79266	Methodist Hospital - South	Shelby	6	0	1,089	1,245	2,334	389
79396	Saint Francis Hospital	Shelby	22	0	3,428	5,837	9,265	421
79516	Saint Francis Hospital - Bartlett	Shelby	4	0	3,569	3,747	7,316	1,829
79256	Saint Jude Children's Research Hospital	Shelby	2	2	681	1,214	1,895	948
79246	The Regional Medical Center at Memphis	Shelby	13	0	8,579	4,519	13,098	1,008
84256	Baptist Memorial Hospital	Tipton	4	0	232	1,134	1,366	342
Total			147	2	48,032	46,005	94,037	640

* #of ORs Not Reported on JAR

2011

ID #	Hospitals	Co.	ORs	Ded O/P	I/P	O/P	Total	Proc/OR
24226	Methodist Healthcare	Fayette	2	0	59	506	565	283
79216	Baptist Memorial Hospital	Shelby	26	0	7,644	5,511	13,155	506
79326	Baptist Memorial Hospital - Collierville	Shelby	6	0	1,031	1,758	2,789	465
79506	Baptist Memorial Hospital for Women	Shelby	5	0	875	1,866	2,741	548
79386	Delta Medical Center	Shelby	8	0	2,308	4,661	6,969	871
79306	Lebonheur Children's Medical Center	Shelby	15	0	6,598	3,591	10,189	679
79276	Methodist Healthcare - Memphis Hospitals	Shelby	13	0	6,149	3,532	9,681	745
79236	Methodist Hospital - Germantown	Shelby	16	0	4,661	5,481	10,142	634
79296	Methodist Hospital - North	Shelby	10	0	1,867	871	2,738	274
79266	Methodist Hospital - South	Shelby	6	0	1,037	1,103	2,140	357
79396	Saint Francis Hospital	Shelby	22	0	3,323	5,585	8,908	405
79516	Saint Francis Hospital - Bartlett	Shelby	4	0	4,535	4,566	9,101	2,275
79256	Saint Jude Children's Research Hospital	Shelby	2	4	2981	3,487	6,468	3,234
79246	The Regional Medical Center at Memphis	Shelby	13	0	8,892	4,110	13,002	1,000
84256	Baptist Memorial Hospital	Tipton	4	0	243	964	1,207	302
Total			152	4	52,203	47,592	99,795	657

Source: 2008, 2009, 2010 & 2011(Provisional) Hospital, JARs, Schedule D - Services

Attachment C.OD.3



Total all industries

Memphis, TN-MS-AR MSA, Tennessee

Healthcare Practitioners and Technical Occupations

Occupation	Occ. code	Est. empl.	Mean Wage	Entry wage	Exp. wage	25th Per.	Median Wage	75th Per.
HEALTHCARE PRACTITIONERS AND TECHNICAL OCCUPATIONS	29-0000	40,570	65,467	32,742	81,830	38,969	53,642	71,384
			31.47	15.74	39.34	18.74	25.79	34.32
Chiropractors	29-1011	40	116,874	39,411	155,606	42,894	147,307	
			56.19	18.95	74.81	20.62	70.82	
Dentists, General	29-1021	230	147,531	95,206	173,694	109,792	145,897	
			70.93	45.77	83.51	52.78	70.14	
Dietitians and Nutritionists	29-1031	330	48,846	33,282	56,629	38,206	47,014	56,420
			23.48	16.00	27.23	18.37	22.60	27.12
Optometrists	29-1041	200	148,877	79,033	183,799	92,918	132,622	
			71.58	38.00	88.37	44.67	63.76	
Pharmacists	29-1051	1,790	111,511	86,004	124,264	101,976	115,158	128,797
			53.61	41.35	59.74	49.03	55.36	61.92
Anesthesiologists	29-1061	300						
Family and General Practitioners	29-1062	260	187,009	121,604	219,712	145,563		
			89.91	58.46	105.63	69.98		
Internists, General	29-1063	160	201,941			164,908		
			97.09			79.28		
Obstetricians and Gynecologists	29-1064	60	169,923	61,915	223,926	92,818		
			81.69	29.77	107.66	44.62		
Pediatricians, General	29-1065	270	151,047	79,557	186,792	105,939	156,364	
			72.62	38.25	89.80	50.93	75.18	
Psychiatrists	29-1066	50	155,026	64,179	200,449	92,139	144,880	
			74.53	30.86	96.37	44.30	69.65	
Surgeons	29-1067	360	174,877	53,815	235,408	90,795		
			84.08	25.87	113.18	43.65		
Physicians and Surgeons, All Other	29-1069	1,550	172,485	81,279	218,088	112,010		
			82.93	39.08	104.85	53.85		
Physician Assistants	29-1071	120	90,581	46,336	112,703	63,549	77,817	87,889
			43.55	22.28	54.18	30.55	37.41	42.25
Podiatrists	29-1081		185,463	123,291	216,548	134,111		
			89.16	59.27	104.11	64.48		
Registered Nurses	29-1111	15,060	63,207	46,645	71,487	50,951	59,706	71,460
			30.39	22.43	34.37	24.50	28.70	34.36
Audiologists	29-1121		51,779	47,613	53,862	46,950	50,319	53,764
			24.89	22.89	25.90	22.57	24.19	25.85
Occupational Therapists	29-1122	350	66,993	45,052	77,963	54,788	68,744	84,011
			32.21	21.66	37.48	26.34	33.05	40.39

Physical Therapists	29-1123	760	76,789	57,425	86,471	63,329	76,959	89,053
			36.92	27.61	41.57	30.45	37.00	42.81



Entry and Experienced wages represent the mean of the lower third and the mean of the upper two-thirds of the wage distribution respectively. The OES survey does not collect information for entry or experienced workers. Tennessee Department of Labor & Workforce Development, Employment Security Division, Labor Market Information. Publish date June 2010.



Total all industries Memphis, TN-MS-AR MSA, Tennessee

Healthcare Support Occupations

Occupation	Occ. code	Est. empl.	Mean Wage	Entry wage	Exp. wage	25th Per.	Median Wage	75th Per.
HEALTHCARE SUPPORT OCCUPATIONS	31-0000	13,800	25,626	18,532	29,172	20,248	24,169	29,429
			12.32	8.91	14.03	9.73	11.62	14.15
Home Health Aides	31-1011	1,960	21,162	16,148	23,669	16,794	20,230	24,621
			10.17	7.76	11.38	8.07	9.73	11.84
Nursing Aides, Orderlies, and Attendants	31-1012	5,540	23,021	18,075	25,495	19,563	22,516	26,037
			11.07	8.69	12.26	9.41	10.82	12.52
Occupational Therapist Assistants	31-2011	100	46,302	30,102	54,402	30,482	34,439	64,868
			22.26	14.47	26.15	14.65	16.56	31.19
Occupational Therapist Aides	31-2012	50	21,783	18,955	23,197	19,211	21,083	24,114
			10.47	9.11	11.15	9.24	10.14	11.59
Physical Therapist Assistants	31-2021	280	52,803	39,506	59,452	44,215	52,743	63,681
			25.39	18.99	28.58	21.26	25.36	30.62
Physical Therapist Aides	31-2022	180	22,808	17,804	25,310	18,503	21,161	27,049
			10.97	8.56	12.17	8.90	10.17	13.00
Massage Therapists	31-9011	200	36,797	18,608	45,892	22,673	35,358	52,856
			17.69	8.95	22.06	10.90	17.00	25.41
Dental Assistants	31-9091	1,020	31,486	23,519	35,469	25,054	30,127	38,483
			15.14	11.31	17.05	12.05	14.48	18.50
Medical Assistants	31-9092	2,670	26,928	21,882	29,451	23,468	26,968	30,165
			12.95	10.52	14.16	11.28	12.97	14.50
Medical Equipment Preparers	31-9093		29,010	23,103	31,964	24,888	28,990	33,278
			13.95	11.11	15.37	11.97	13.94	16.00
Medical Transcriptionists	31-9094	240	31,945	27,002	34,416	27,966	31,771	36,461
			15.36	12.98	16.55	13.45	15.27	17.53
Pharmacy Aides	31-9095		22,445	18,623	24,355	18,532	20,289	25,551
			10.79	8.95	11.71	8.91	9.75	12.28
Veterinary Assistants and Laboratory Animal Caretakers	31-9096	270	20,700	15,412	23,343	15,761	18,927	24,866
			9.95	7.41	11.22	7.58	9.10	11.95
Healthcare Support Workers, All Other	31-9099	750	30,345	21,285	34,875	23,757	28,658	37,723
			14.59	10.23	16.77	11.42	13.78	18.14



Entry and Experienced wages represent the mean of the lower third and the mean of the upper two-thirds of the wage distribution respectively. The OES survey does not collect information for entry or experienced workers. Tennessee Department of Labor & Workforce Development, Employment Security Division, Labor Market Information. Publish date June 2010.

**The Commercial Appeal
Affidavit of Publication**

2012 DEC 14 AM 10 32

**STATE OF TENNESSEE
COUNTY OF SHELBY**

Personally appeared before me, Patrick Maddox, a Notary Public, Helen Moriarty, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached notice was published in the following edition of The Commercial Appeal to-wit:

December 10, 2012

Helen Moriarty

Subscribed and sworn to before me this 10th day of December, 2012

Patrick Maddox Notary Public

My commission expires 2/15/14



My Commission Expires 02/15/2014

[illegible]

The estimated project cost is anticipated to be approximately \$7, which includes the cost of photocopies.

Dated and filed at the District Court of the State of Tennessee, Davidson County, this 10th day of December, A.D. 2012.

Cecilia Beazley, Attorney who may be contacted by the applicant.
1821 Riverland Jones Road, Suite 300, Nashville, TN 37215, 615.370.3300.

A written request by interested parties for local Fact-Finding public hearing shall be conducted. Written requests for hearings should be sent to:

Health Services and Department Agency
Andrew Jackson Building
500 Deshauford Street, Suite 650
Nashville, Tennessee 37203

Unpublished Letter of Intent must commit the following statement to T.C.A., § 68-11-607(e)(1). Any health care institution that opposes a Certificate of Need application has the right to petition the Health Services and Development Agency no later than 90 days before the regulatory board's meeting. The Health Services and Development Agency meeting at which the application is originally submitted and (B) Any other person wishing to oppose the application must file a written objection with the Health Services and Development Agency prior to the consideration of the application by the agency.



State of Tennessee

Health Services and Development Agency

Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

March 1, 2013

E. Graham Baker Jr., Esq.
2021 Richard Jones Road, Suite 350
Nashville, TN 37215

RE: Certificate of Need Application -- Spinal Health Care Associates, P.C. - CN1212-060

Dear Mr. Baker:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the establishment of a specialty ASTC providing only manipulation under anesthesia (MUA) services in Cordova (Shelby County), TN. The estimated project cost is \$472,667.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on March 1, 2013. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on May 22, 2013.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
 - (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in
-

E. Graham Baker Jr., Esq.
March 1, 2013
Page 2

review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read "Melanie M. Hill". The signature is fluid and cursive, with the first name "Melanie" being more prominent than the last name "Hill".

Melanie M. Hill
Executive Director

cc: Lori Ferranti, Director, TDH, PPA




State of Tennessee

Health Services and Development Agency

Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

MEMORANDUM

TO: Lori Ferranti, Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 Fifth Avenue North
Nashville, Tennessee 37247

FROM: 
Melanie M. Hill
Executive Director

DATE: March 1, 2013

RE: Certificate of Need Application
Spinal Health Care Associates, P.C. - CN1212-060

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on March 1, 2013 and end on May 1, 2013.

Should there be any questions regarding this application or the review cycle, please contact Mark Farber, Deputy Director.

Enclosure

cc: E. Graham Baker Jr., Esq.



DEC 7 PM 1 56

LETTER OF INTENT TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Commercial Appeal which is a newspaper of general
(Name of Newspaper)

circulation in Shelby and surrounding Counties, Tennessee on or before 12/10/2012 for one day.
(County) (Month / day) (Year)

=====

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that Spinal Health Care Associates, P.C. ("Applicant"), 8132 Cordova Road, Suite 101, Cordova, TN 38106, owned by Rock Wooster, D.C., 8132 Cordova Road, Suite 102, Cordova, TN 38106, and managed by itself, intends to file an application for a Certificate of Need for establishment of a specialty ambulatory surgical treatment center ("ASTC") providing only manipulation under anesthesia ("MUA") services. This new ASTC will be located in an existing building, and will have one (1) procedure room, one (1) exam room, one (1) recovery room, along with other related space. The Applicant will provide only MUA and related services, which are manual surgical procedures, and no operative surgical procedures will be performed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that the specialty ASTC will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately \$474,667, which includes the cost of the filing fee.

The anticipated date of filing the application is: December 14, 2012.

The contact person for this project is E. Graham Baker, Jr. Attorney
(Contact Name) (Title)

who may be reached at: his office located at 2021 Richard Jones Road, Suite 350
(Company Name) (Address)

Nashville TN 37215 615 / 370-3380
(City) (State) (Zip Code) (Area Code / Phone Number)

E. Graham Baker, Jr. 12/07/2012 graham@grahambaker.net
(Signature) (Date) (E-mail Address)

=====

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

=====

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

=====

* The project description must address the following factors:



STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

December 18, 2012

E. Graham Baker, P.C.
Weeks and Anderson
2012 Richard Jones Road, Suite 350
Nashville, TN 37215

RE: Certificate of Need Application CN1212-060
Spinal Healthcare Associates, PC

Dear Mr. Baker:

This will acknowledge our December 14, 2012 receipt of your application for a Certificate of Need for the establishment of a specialty ambulatory surgical center (ASTC) providing manipulation under anesthesia (MUA) services in an existing building located at 8132 Cordova Road, Suite 101, Cordova (Shelby County), TN 38106.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Wednesday December 26, 2012. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

1. Section A, Item 4

The Secretary of State corporate verification for Spinal Health Associates, P.C. is noted. However, please clarify the following;

- Please clarify the active assumed names of Shelby County Pain Clinic, Health Touch Body Works, and Cordova Pain Treatment Center listed under Spinal Health Care Associates, P.C. and their relationships.

Please explain the reason Spinal Health Care Associates, P.C is registered with the Tennessee Secretary of State as Suite 102, 8132 Cordova Road, while the applicant lists the location of the proposed facility as 8132 Cordova Road, Suite 101.

Who are the officers and/or members of Spinal Health Associates, P.C.?

Please clarify if Shelby County Pain Clinic, 8132 Cordova Road, Suite 102, Cordova, TN 38016 is associated with this project. If so, please verify this pain clinic is registered with the State of Tennessee. Also, please provide the name of the Medical Director and copy of license verification, any board orders, if applicable, from the following web-site: <http://health.state.tn.us/licensure/default.aspx>.

The NPES (National Plan and Provider Enumeration System) lists Spinal Health Care Associates, P.C. NPI number as 1316137243 with an address of 8132 Cordova Road, Suite 102, Cordova, TN 38016. Please verify if either Shelby County Pain Clinic and Cordova Pain Treatment Center also files claims under this NPI number. If so, please explain why there is not a separate NPI number for each business. Also, will this proposed project also file claims under NPI 1316137243?

2. Section A, Item 6

The statement is made “the applicant will lease space from Rock A. Wooster and Jason Coleman, the landlord”. Is this a sublease? Please clarify and resubmit a replacement page if necessary.

3. Section A, Item 12

Please clarify if the applicant Spinal Healthcare Associates, P.C or Rock Wooster, D.C. is currently a contracted provider for AmeriChoice, BlueCare or TennCare Select.

The applicant is projecting a TennCare payor mix of 80% (\$1,560,000) in Year One of the project. Please explain how this is possible while the applicant states “the applicant will take any TennCare patient out of network. If reimbursement is not available, the procedures will be written off as charity care”.

Please refer to the BlueCross BlueShield of Tennessee Policy http://www.bcbst.com/mpmanual/Spinal_Manipulation_Under_Anesthesia.htm and respond to the following questions:

- According to the above BCBST policy what type of MUA procedures are considered investigational?
- When are MUA procedures medically appropriate?

Please attach a copy of the above mentioned BCBST MUA policy.

The applicant is projecting 15% Medicare patients for the proposed project. How is this possible while the applicant is stating the average age range for traditional MUA patients is 25-62?

Please review the Rules of the Bureau of TennCare (1200-13-16-.05 (1) (d)) at the following web-site, <http://tennessee.gov/sos/rules/1200/1200-13/1200-13-16.pdf> regarding medical necessity criteria. If MUA is considered investigational by Blue Cross Blue Shield of Tennessee how can TennCare revenue be projected at 80% of the proposed project?

The statement "MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it cannot be recognized by legal definition as an experimental or investigational procedure is noted". Please provide a reference from the AMA CPT billing guidelines to substantiate this statement.

The statement "we are aware of several insurance companies that reimburse for MUA care, but reimburse at discounted rates" is noted. Please provide the names of these mentioned companies and the amount of the discounted rates. Also, was this information factored into the projected data chart?

Please provide the coverage rationale (proven or unproven) according to United Healthcare, Manipulation Under Anesthesia: Medical Policy (Effective 5/1/12). Please respond to the above question by referencing the UnitedHealthcare Manipulation Under Anesthesia medical policy at the following web-site:

https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Manipulation_Under_Anesthesia.pdf

Please indicate if there have been any discussions by the applicant with any TennCare MCO's regarding contracting for this proposed project. If so, what is the stage of discussion?

The statement "we are not sure if reimbursement will be available for such patients until such time as we actually provide the procedures and submit the claims for payment" in regard to TennCare patients is noted. If MUA procedures have a gross charge of \$15,000 would it not be practical to determine if an insurance plan will reimburse an MUA claim prior to providing the service?

4. Section B, Project Description, Item I

The injecting of anti-inflammatory medication into painful joint using Manipulation Under Joint Anesthesia (MUJA) is noted. Please explain how these injections are used as a screening tool and describe the length of therapy. What are the CPT codes billed for MUJA procedures?

What is the expected percentage of total procedures that will be MUJA?

Does the applicant now receive reimbursement for MUJA procedures from TennCare?

Describe the MUA continuum of care.

How many MUA procedures has the applicant performed?

Are MUA procedures being performed now by the applicant in an office setting?

Please identify the physician, nurse and anesthesiologist who will be assisting with MUA in the proposed project.

The average charge of \$15,000 per patient is noted. What is the cost of the actual MUA procedure?

Please elaborate regarding the need for this project and why the applicant is seeking approval of the proposed service as an ASTC (Ambulatory Surgical Treatment Center)?

Please indicate if the proposed project will be providing manual procedures in a clean environment as opposed to traditional ASTC operative procedures in a sterile environment.

Please clarify if this proposed project is associated with existing MUA clinics in Nashville and Knoxville.

Please clarify if other chiropractors will have access to this ASTC to conduct MUA procedures.

5. Section B, Project Description, Item II A

The purchase of a C-Arm in the amount of \$40,000 is noted. Please indicate what type of equipment this is and its importance in conducting MUA procedures. Is there a separate patient charge for the use of this equipment?

6. Section B, Project Description Item III (Plot Plan) and Item IV (Simple Drawing)

The applicant notes \$100,000 for construction cost in the narrative but places "possible renovation" in parenthesis in the amount of \$100,000 in the Project Costs Chart. Please clarify.

The floor plan of the proposed site is noted. Please explain why the simple line drawing is titled "Cordova Pain Management, Ambulatory Surgery Center Floor plan".

7. Section C, Need, Item 1.a (Service Specific Criteria-ASTC)

Please clarify how the applicant can appropriately address any of the ASTC specific criteria while it is unknown if Medicare, TennCare and commercial insurance reimburse for MUA services.

8. Section C, Need, Item 1.a (Service Specific Criteria-ASTC (4)

Please indicate when the applicant projects to perform a minimum of 800 cases per room.

9. Section C, Need, Item 4.B.

Please indicate if there are any special needs of the service area population other than overmedicating patients with painkillers. How will the long-range plans of the facility take into consideration the special needs identified in the service area population?

10. Section C, Need Item 5

The applicant mentions Robert C. Gordon, D.C. has trained all the doctors in This proposed project. Please verify Robert C. Gordon is licensed in the State of Tennessee as a D.C.

11. Section C, Economic Feasibility, Project Costs Chart

There is a calculation error in the Project Costs Chart. Please correct and resubmit.

12. Economic Feasibility, Item 2, Project Funding

The letter from First Tennessee verifying \$200,000 to implement the proposed project is noted. However, the applicant plans to maintain an average monthly balance sufficient to serve as cash reserves. Since the 80% of the projected revenue is TennCare and there is a probability of a large number of charity care, please provide additional documentation of adequate cash reserves to cover the balance and any additional unforeseen projects costs.

The Spinal Healthcare Associates P.C. Balance Sheet indicates a loan to Shareholder in the amount of \$586,685.39. Since this is a large percentage of current assets, what is the purpose of this loan?

13. Economic Feasibility, Item 3

Please compare the renovated cost per GSF to other ASTC projects for Years 2009-2011 using the applicant's toolbox on HSDA's web-site located at http://tennessee.gov/hsda/applicants_tools/app_tool_box.shtml

14. Economic Feasibility, Item 4, Projected Data Chart

The applicant has stated in the application one fee will be charged to patients. Please explain how this fee is calculated.

A Medical Director is listed on the Projected Data Chart at a cost of \$210,000 per year. Please indicate the name of the Medical Director and his/her background.

There is an error in the amount in the Year 2 column under insurance. Please correct and resubmit a replacement page.

15. Section C., Economic Feasibility, Item 5

The statement clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy and anesthesiologists will bill for their own perspective services is noted. Please indicate the estimated amount these providers will charge outside the MUA procedure. Also, if the applicant accepts a charity case does that guarantee the above professionals will not bill?

16. Section C, Economic Feasibility, Item 6.B

Please indicate the top 10 projected CPT reimbursed procedures for this proposed project.

CPT Code	Brief Description	Amount

The applicant has provided some common CPT codes. Please complete the following table in regards to BlueCare and AmeriChoice:

CPT Code	Description	Covered by AmeriChoice? Y/N	Covered by BCBST?Y/N
22505			
27275			
23700			
27194			
24300			
26340			
27870			
27860			

17. Section C, Orderly Development, Item 1

Please indicate if there are any transfer agreements with any hospitals. If so, please list those hospitals.

Please indicate if practitioners who will provide care at the proposed MUA ASTC will have admitting privileges at area hospitals. If so, please list those hospitals.

18. Section C, Orderly Development, Item 4

Please provide a copy of the license of providers who have been identified to provide clinical services in this project.

19. Section C, Orderly Development, Item 5

The statement "certain waivers will be requested as no operative surgical procedures will take place" is noted. Is the applicant referring to two ASTC regulations that were waived during the Board for Licensing Health Care

Facilities meeting on May 12, 2009 for MUA Medical Clinics in Brentwood and Knoxville? If so, please explain.

20. Section C, Orderly Development, Item 8

The Tennessee Department of Licensure Practitioner Profile Data information indicates there was an above settlement reported on January 23, 2008 for Rock Wooster, DC. Please describe this above average settlement.

Also, there appears to be adverse license actions associated with Rock Wooster. Please provide a copy of the board order dated March 31, 2011 from the Department of Health Licensure web-site. The address of the web-site is http://health.tn.gov/DisciplinaryExclusion/boardorder/display/1108_830_033111

According to the Bank Records provided, it appears Chiropractic Physicians Jason Coleman and Jeffrey Becker are associated with the proposed project. Please provide web-based verification of their licenses and copies of any board orders by the Tennessee Board of Chiropractic Examiners.

21. Section C, Orderly Development, Item 12

The applicant mentions MUA facilities in Knoxville and Nashville. Please indicate if these facilities are contracted with TennCare MCOs and Medicare for MUA services.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Friday February 15, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person

unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

A handwritten signature in cursive script, reading "Phillip M. Earhart".

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

PME
Enclosure

COPY-

SUPPLEMENTAL-1

Spinal Healthcare Associates, PC
CN1212-060

WEEKS & ANDERSON

An Association of Attorneys

**2021 RICHARD JONES ROAD, SUITE 350
NASHVILLE, TENNESSEE 37215-2874
TELEPHONE 615/383-3332
FACSIMILE 615/383-3480**

KENT M. WEEKS
ROBERT A. ANDERSON

DIRECT TELEPHONE NUMBER: 615/370-3380

SUPPLEMENTAL- # 1

**February 11, 2013
12:55pm**

F. B. MURPHY, JR.
E. GRAHAM BAKER, JR.

February 11, 2013

Phillip M. Earhart
Health Services Development Examiner
Tennessee Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Supplemental Information: Certificate of Need Application CN1212-060
Spinal Healthcare Associates, PC

Dear Phillip:

Enclosed are three (3) copies of responses to your supplemental questions regarding the referenced Certificate of Need application. If you have any additional questions, please contact me.

Sincerely,



E. Graham Baker, Jr.

/np

Enclosures as noted

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Spinal Healthcare Associates, PC (CN1212-060)

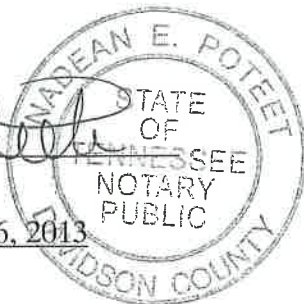
I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E. Graham Baker, Jr. Attorney at Law
Signature/Title

Sworn to and subscribed before me, a Notary Public, this 11th day of February, 2013; witness my hand at office in the County of Davidson, State of Tennessee.

Nadean E. Poteet
NOTARY PUBLIC

My Commission expires May 6, 2013



1. **Section A, Item 4**

The Secretary of State corporate verification for Spinal Health Associates, P.C. is noted. However, please clarify the following:

- **Please clarify the active assumed names of Shelby County Pain Clinic, Health Touch Body Works, and Cordova Pain Treatment Center listed under Spinal Health Care Associates, P.C. and their relationships.**

Response: These "d/b/a" names have been used in the past for marketing purposes, as follows:

Shelby County Pain Clinic is our d/b/a for pain management procedures, injections, x-rays, TENS units, braces, etc.;

Health Touch Body Works is our d/b/a for message therapy; and

Cordova Pain Treatment Center is an old d/b/a that is still registered but inactive. All services previously provided through this d/b/a are now provided through Shelby County Pain Clinic.

Please explain the reason Spinal Health Care Associates, P.C is registered with the Tennessee Secretary of State as Suite 102, 8132 Cordova Road, while the applicant lists the location of the proposed facility as 8132 Cordova Road, Suite 101.

Response: The Applicant, as noted in response to Question A.1 of the Application, is Spinal Health Care Associates, P.C. The Applicant is owned by Rock Wooster, D.C., as noted in response to Question A.3 of the Application.

Dr. Wooster's existing practice is called Spinal Health Care Associates, P.C. As such, it is located where his office practice is currently located – in Suite 102. The actual ASTC that is the subject of this CON application will be located in an adjacent space, which is Suite 101. At present, Suite 101 is not being utilized. Therefore, if this Application is approved, the requested ASTC will be located in Suite 101, next door to its Owner. It will be also be known as Spinal Health Care Associates, P.C. The potential utilization of Suite 101 if this Application is not approved will be decided by the landlord and is not in the province of this review.

Who are the officers and/or members of Spinal Health (sic) Associates, P.C.?

Response: Rock A. Wooster, D.C. is President, David Crawford, M.D. is Vice President, and Jason Colman, D.C. is Secretary. These same three individuals are the only members.

Please clarify if Shelby County Pain Clinic, 8132 Cordova Road, Suite 102, Cordova, TN 38016 is associated with this project. If so, please verify this pain clinic is registered with the State of Tennessee. Also, please provide the name of the Medical Director and copy of license verification, any board orders, if applicable, from the following web-site:
<http://health.state.tn.us/licensure/default.aspx>.

Response: Shelby County Pain Clinic is a d/b/a of Spinal Health Associates, P.C., the Owner as stated above, and is registered with the State of Tennessee (see *Supplemental A.4*). David Crawford, M.D. is the medical director. A copy of Dr. Crawford's medical license is attached as *Supplemental A.4.1*.

The NPPES (National Plan and Provider Enumeration System) lists Spinal Health Care Associates, P.C. NPI number as 1316137243 with an address of 8132 Cordova Road, Suite 102, Cordova, TN 38016. Please verify if either Shelby County Pain Clinic and Cordova Pain Treatment Center also files claims under this NPI number. If so, please explain why there is not a separate NPI number for each business. Also, will this proposed project also file claims under NPI 1316137243?

Response: Everything is filed under Spinal Health Care Associates, P.C. As stated above, the d/b/a of Cordova Pain Treatment Center is no longer used. The number cited above is the NPI number for Spinal Health Care Associates, P.C. The other mentioned entities are merely d/b/a entities, meaning they are the same business, and therefore neither have nor need separate NPI numbers. The Applicant anticipates having a separate NPI for the ASTC, which will be separately licensed. As the ASTC has not been approved, it has no existing NPI.

2. Section A, Item 6

The statement is made “the applicant will lease space from Rock A. Wooster and Jason Coleman, the landlord”. Is this a sublease? Please clarify and resubmit a replacement page if necessary.

Response: It is a lease; no replacement page is necessary. At the time of filing this application, Rock A. Wooster, D.C. and Jason Coleman, D.C. owned the building. These two individuals were both the owner and the landlord. The Applicant will lease space from the owner/landlord of the building.

Following the submission of this application, Dr. Coleman transferred his ownership in the building to Dr. Wooster in exchange for the cancellation of personal debt owed to Dr. Wooster. Dr. Wooster is now the owner/landlord, and has assumed all of the obligations and existing contracts, including the instant lease.

3. Section A, Item 12

Please clarify if the applicant Spinal Healthcare Associates, P.C or Rock Wooster, D.C. is currently a contracted provider for AmeriChoice, BlueCare or TennCare Select.

Response: Spinal Healthcare Associates, P.C. is currently contracted with all three entities cited above. Rock Wooster, D.C. is not a contracted provider, as MCOs will not contract with chiropractors.

The applicant is projecting a TennCare payor mix of 80% (\$1,560,000) in Year One of the project. Please explain how this is possible while the applicant states "the applicant will take any TennCare patient out of network. If reimbursement is not available, the procedures will be written off as charity care".

Response: With no ASTC in West Tennessee that specializes in MUA, it is impossible to estimate with specificity what our payor mix will be. MUA treatment is relatively new to Tennessee, and the two approved facilities (Knoxville and Nashville) have only recently opened. As such, there is no way to investigate the exact payor mixes of these two existing facilities, as no JARs have been filed.

When we filed this application, Dr. Wooster's practice was approximately 80% TennCare and 20% Medicare and Commercial. Most of his TennCare patients were also certified as Medicare patients. We felt similar percentages would possibly follow into the ASTC. It is noteworthy that, as stated, most of the patients we currently see that are on TennCare are also on Medicare. We now know that TennCare pays for many MUA procedures. However, if TennCare will not pay and the patient qualifies for Medicare, we will bill through Medicare. We may have to write off TennCare co-pays, but we made allowances for such when we completed the Projected Data Chart.

Please refer to the BlueCross BlueShield of Tennessee Policy http://www.bcbst.com/mpmanual/Spinal_Manipulation_Under_Anesthesia.htm and respond to the following questions:

According to the above BCBST policy what type of MUA procedures are considered investigational?

Response: To quote directly from the BCBST Policy that you reference:

"POLICY

- "Manipulation under anesthesia is considered *medically necessary* if the medical appropriateness criteria are met. (See Medical Appropriateness below).

- "Manipulation under anesthesia for other joints including the wrist, elbow, hand, finger, ankle, and pelvis, in the absence of fracture or complete dislocation, is considered **investigational**."
- "Spinal manipulation under anesthesia, (e.g. general anesthesia, joint anesthesia, epidural anesthesia with corticosteroid injections) as a treatment for conditions including, but not limited to chronic spinal pain (e.g. cranial, cervical, thoracic, and lumbar) and chronic sacroiliac and pelvic pain, is considered **investigational**."
- "Spinal manipulation and manipulation of other joints under anesthesia involving serial treatment sessions (greater than 1 treatment) is considered **investigational**."

It is evidently important to restate a passage from the application (pages 13 and 14):

"Unfortunately, there still remain a few insurance companies that consider MUA an experimental or investigative procedure. Some providers have surmised that an insurance company receives monthly premiums from policy holders and is supposed to pay for covered procedures if and when the policy holders submit claims. The more claims that are paid, the less profit for the insurance company. If the insurance company does not want to pay the claim, there are several responses to such claims which either decrease the possibility of paying the claim, or at least, delay the payment. These responses include, but are not limited to, "You aren't covered; this procedure isn't covered; this procedure is experimental; the paperwork for the claim isn't completed properly; the claimant had a pre-existing condition which was not divulged on the application form; we have no record of your claim;" etc. Any delay is a delay.

"However, it is a fact that MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it can not be and is not recognized by legal definition as an experimental or investigative procedure. Insurance carriers that are designating MUA of any area as experimental or investigative have the burden of proof to defend their position that this procedure is experimental. To date, such attempts have been unsuccessful in a court of law. Therefore, since MUA is considered a Category 1 procedure by CPT, it is neither an experimental nor an investigative procedure."

Further, your attention is directed to *Supplemental A.12.1*, which is a March 27, 2008 letter from the American Medical Association which states that MUA procedures are NOT considered investigative or experimental.

When are MUA procedures medically appropriate?

Response: It is far beyond the purview of this application to explain what specific procedures, medications, and services are, or are not, medically appropriate for specific patients. Such decisions are made by licensed professionals on a case-by-case basis, and then approved or disapproved by insurance companies and governmental reimbursement programs (such as Medicaid and Medicare, or their respective third-party payors).

From a general perspective, as stated in *Supplemental A.12.2*, "Spinal manipulation under anesthesia is a procedure that is intended for patients that suffer from **sometimes** acute,

but mostly chronic musculoskeletal disorders in conjunction with biomechanical aberrancies. These individuals have also been minimally responsive to previous conservative therapy.”

(*Source of Supplemental A.12.2: MANIPULATION UNDER ANESTHESIA (MUA), A medication assisted manipulation (MAM), Class syllabus & reference Guide. Instructor: Robert C Gordon, D.C., FABCS, FRCCM, DAAPM. Cornerstone Professional Education, Inc., Revised 2010*)

Further, the Application stated on page 10:

“MUA is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the 1930s. Leading references put the use of MUA in the United States as far back as 1938, when Persols International Medical Clinic from Great Britian brought the procedures to the United States through Doctors Shiel, Clauborne, Mensor, and others, as reported in the Bibliography in the textbook, “Manipulation Under Anesthesia, Concepts In Theory and Application,” Gordon, R., et.l., Taylor and Francis, April 2005. The process involves relaxing the patient (with anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

“MUA also includes MUJA, which stands for Manipulation Under Joint Anesthesia, and involves injecting anti-inflammatory medication into painful inflamed joints both in conjunction with the biomechanical alterations accomplished with the MUA techniques, and as a screening tool. Patients suffering more severe or complex joint pain have a better response to the MUA techniques when afforded this medication. However, if such a joint injection completely alleviates the pain, such blocks may well preclude the need for additional MUA procedures for some patients. In effect, MUJA procedures are part of the MUA continuum of care.”

Please attach a copy of the above mentioned BCBST MUA policy.

Response: Please see attached BCBST Medical Policy Manual section on MUA (*BCBST-MUA*).

Finally, please note *Supplemental A.12.3*, which is a list of approved CPT codes, along with maximum allowable charges, issued to the Applicant by BlueCare. This list of approved BlueCare CPT codes includes CPT codes for MUA procedures. Obviously, BlueCare reimburses for MUA procedures.

The applicant is projecting 15% Medicare patients for the proposed project. How is this possible while the applicant is stating the average age range for traditional MUA patients is 25-62?

Response: Various types of maladies are covered by Medicare, irrespective of the age of the patient, including: diabetes; overweight; heart disease; and other disabilities. The majority of our patients are under the age of 65. Further, most of our Medicare patients are under the age of 60.

Please review the Rules of the Bureau of TennCare (1200-13-16-.05 (1) (d)) at the following web-site, <http://tennessee.gov/sos/rules/1200/1200-13/1200-13-16.pdf> regarding medical necessity criteria. If MUA is considered investigational by Blue Cross Blue Shield of Tennessee how can TennCare revenue be projected at 80% of the proposed project?

Response: The Applicant contends that BCBST has the burden of proving such procedures are investigational and/or experimental. To date, no insurance carrier has been able to convince a court of law that such procedures are investigational and/or experimental. Again, it is important to restate a passage from the application (pages 13 and 14):

“Unfortunately, there still remain a few insurance companies that consider MUA an experimental or investigative procedure. Some providers have surmised that an insurance company receives monthly premiums from policy holders and is supposed to pay for covered procedures if and when the policy holders submit claims. The more claims that are paid, the less profit for the insurance company. If the insurance company does not want to pay the claim, there are several responses to such claims which either decrease the possibility of paying the claim, or at least, delay the payment. These responses include, but are not limited to, “You aren’t covered; this procedure isn’t covered; this procedure is experimental; the paperwork for the claim isn’t completed properly; the claimant had a pre-existing condition which was not divulged on the application form; we have no record of your claim;” etc. Any delay is a delay.

“However, it is a fact that MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it can not be and is not recognized by legal definition as an experimental or investigational procedure. Insurance carriers that are designating MUA of any area as experimental or investigational have the burden of proof to defend their position that this procedure is experimental. To date, such attempts have been unsuccessful in a court of law. Therefore, since MUA is considered a Category 1 procedure by CPT, it is neither an experimental nor an investigational procedure.”

Further, your attention is directed to *Supplemental A.12.1*, which is a March 27, 2008 letter from the American Medical Association which states that MUA procedures are NOT considered investigational or experimental.

Finally, please note *Supplemental A.12.3*, which is a list of approved CPT codes, along with maximum allowable charges, issued to the Applicant by BlueCare. This list of approved BlueCare CPT codes includes CPT codes for MUA procedures. Obviously, BlueCare reimburses for MUA procedures.

Since insurance carriers have, to date, failed to show that MUA procedures are investigational and/or experimental in a court of law, the Applicant believes that payment for these procedures will be made.

The statement "MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it cannot be recognized by legal definition as an experimental or investigational procedure is noted". Please provide a reference from the AMA CPT billing guidelines to substantiate this statement.

Response: To the knowledge of the Applicant, the AMA CPT "billing guidelines" make no such statements to substantiate our assertion. We rely on the AMA letter. It is our understanding, based on the AMA letter and its attachment, that the mere fact the CPT code exists means the procedure is neither experimental nor investigational. Please see *Supplemental A.12.1*.

The statement "we are aware of several insurance companies that reimburse for MUA care, but reimburse at discounted rates" is noted. Please provide the names of these mentioned companies and the amount of the discounted rates. Also, was this information factored into the projected data chart?

Response: We have been advised that BCBST reimburses for MUA care, but at discounted rates. Anecdotally, we heard from other ASTCs that specialize in MUA care about this process, and were advised to discount some of our anticipated CPT codes by general percentages, which we did. The exact amount of discounted rates were not specified, nor would they be expected due to anti-trust laws.

Please provide the coverage rationale (proven or unproven) according to United Healthcare, Manipulation Under Anesthesia: Medical Policy (Effective 5/1/12). Please respond to the above question by referencing the UnitedHealthcare Manipulation Under Anesthesia medical policy at the following web-site:

<https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Reso>

urces/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Manipulation Under Anesthesia.pdf

Response: The Applicant believes that the cited United Healthcare document, entitled "Medical Policy, Manipulation Under Anesthesia," and dated May 1, 2012, evidently describes its own coverage rationale for MUA, and speaks for itself. Any statement beyond what is cited in United Healthcare's document should originate from United Healthcare, as it would be inappropriate for the Applicant to speculate about United Healthcare's rationale. This cited document is printed out and included with these responses as *UHC-MUA Policy*.

Please indicate if there have been any discussions by the applicant with any TennCare MCO's regarding contracting for this proposed project. If so, what is the stage of discussion?

Response: No. We have discussed reimbursement by various MCOs with other MUA facilities, but we are waiting approval for our facility prior to having direct discussions.

The statement "we are not sure if reimbursement will be available for such patients until such time as we actually provide the procedures and submit the claims for payment" in regard to TennCare patients is noted. If MUA procedures have a gross charge of \$15,000 would it not be practical to determine if an insurance plan will reimburse an MUA claim prior to providing the service?

Response: If a patient needs MUA, we would recommend that the patient receives such treatment. As such, we would request pre-authorization. However, pre-authorization does not mean the treatment will be reimbursed. Reimbursement procedures change each year. Our gross charges are based on what we feel are appropriate charges for the services we provide. As is well known, both governmental programs such as Medicare and TennCare, and commercial insurance companies will pay what they will pay. We will negotiate these reimbursement rates with the various entities following approval of our ASTC.

4. Section B, Project Description, Item I

The injecting of anti-inflammatory medication into painful joint using Manipulation Under Joint Anesthesia (MUJA) is noted. Please explain how these injections are used as a screening tool and describe the length of therapy. What are the CPT codes billed for MUJA procedures?

Response: MUJA is a tool used by MUA providers as part of the provision of MUA services, which tool was anticipated, expected, and approved by the JCAHO accreditation team at the Knoxville MUA ASTC when it was inspected, obviously based on JCAHO's experience in MUA facilities around the country. MUJA is also mentioned in the United Healthcare MUA Policy document (described earlier and included as UHC-MUA Policy) as being a part of MUA.

In order for the MUA team to properly conduct MUA, a patient has to exhaust other conservative methods to decrease the restrictions in the affected joints (both in the spine and the extremities) in an attempt to get range of motion restored. The purpose of the joint injections is to decrease inflammatory response at the joint, help break down adhesions formed in the joint, and to decrease the formation of new scar tissue which decreases the range of motion in the joint. Therefore, MUJA is ancillary to MUA in the fact that by doing MUJA, often times MUA can be avoided.

All joint injections are administered by licensed medical physicians (M.D.s and D.O.s). The only meds being administered are: betamethasone, marcaine and/or lidacaine, and depomedrol (propofol is still administered during MUA, but such injections are not into the joints, and such injections are never administered by a Doctor of Chiropractic).

MUJA is never performed on a patient at the same time MUA procedures are performed; and, in fact, MUJA is always performed by licensed medical physicians (M.D. or D.O.) at all times. Doctors of Chiropractic not only do not perform these injections (as they are not licensed to do so), but they are usually not even present when M.D.s and D.O.s provide MUJA services. MUJA involves injecting anti-inflammatory medication into painful inflamed joints in conjunction with the biomechanical alterations accomplished with MUA, and also as a screening tool prior to the provision of MUA. The length of therapy varies from patient to patient. Some patients experience relief from pain after a single session. Other patients may take longer.

Further, your attention is directed to the United Healthcare MUA policy document referenced above, which states:

"Manipulation under anesthesia (MUA) may be accompanied by fluoroscopically-guided intraarticular injections with corticosteroid agents to reduce inflammation or manipulation under joint anesthesia/analgesia (MUJA). Manipulation under epidural anesthesia (MUEA) employs an epidural, segmental anesthetic, often with simultaneous epidural steroid injections, followed by spinal manipulation therapy. Other therapies may combine manipulation with cortisone injections into paraspinal tissues or joint spaces."

The anticipated length of therapy for sample procedures are as follows:

MUJA code	Procedure	Treatment time	How often	Booster
64493	Lumbar	3	2nd- 1 week later 3rd-2 weeks later 4th-2 weeks later	3 months and every 3 months following if necessary
64494	additional facet joint		if needed	
64495	additional facet joint		if needed	
64490	Cervical	3	2 weeks	3 months
64491	additional facet joint		if needed	
64492	additional facet joint		if needed	
64490	Thoracic	3	2 weeks	3 months
64491	additional facet joint		if needed	
64492	additional facet joint		if needed	
20605	Ankle	1	3 months	
20605	Wrist	3	2 weeks	3 months
20605	Elbow	1	may repeat in 10 days if necessary	3 months
20610	Shoulder	2	2 weeks	3 months
20610	Hip	2	2 weeks	3 months
27096	SI	2	2 weeks	3 months
20610	Knee w supartz	3-5	1 week	NO BOOSTER
20610	Knee w steriods	2	1 week	3 months
20552	Trigger Points 1-2 muscle	as needed	as needed	
20553	3 or more muscles	as needed	as needed	

What is the expected percentage of total procedures that will be MUJA?

Response: The Applicant did not include any estimates of MUJA procedures when projecting income/expenses for this application.

Does the applicant now receive reimbursement for MUJA procedures from TennCare?

Response: No.

Describe the MUA continuum of care.

Response: Patients normally require multiple MUA procedures. Most patients require around 3 procedures to alleviate chronic pain. Some providers perform these procedures on three consecutive days, and some instances indicate three procedures over a three week period, etc. The frequency and exact number of procedures is always dependent on the needs of the patients.

All MUA patients should continue with 6-8 weeks of post physical therapy.

How many MUA procedures has the applicant performed?

Response: Dr. Wooster has performed 30 procedures on ten patients during his training.

Are MUA procedures being performed now by the applicant in an office setting?

Response: No. Such would be in direct violation of the policy of the Tennessee Board of Chiropractic Examiners.

Please identify the physician, nurse and anesthesiologist who will be assisting with MUA in the proposed project.

Response: David Crawford, M.D. is our physician; Brenda Bailey, Lachaundra McCord, Lolita Horton are our NPs; and an anesthesiologist has not been hired.

The average charge of \$15,000 per patient is noted. What is the cost of the actual MUA procedure?

Response: Since we are not providing MUA at present, we can only estimate our costs. Our Projected Data Chart indicates the following rounded estimates, per patient:

Average Gross Charge	\$15,000
Average Deductions	9,191
Average Net Charge	5,809
Average Operating Expense	4,299 (estimated "cost")
Average Profit	\$ 1,510

Again, the above figures are rounded estimates.

Please elaborate regarding the need for this project and why the applicant is seeking approval of the proposed service as an ASTC (Ambulatory Surgical Treatment Center)?

Response: There is no one in this area providing this service. The next nearest location is in Nashville, and it is too far to travel for most patients, especially when consideration is given to each patient having multiple (at least three) procedures. The need for the

Nashville facility was established when only a few chiropractors were involved, and the need for the Knoxville facility was established when only one chiropractor was involved. This particular project involves at least two chiropractors; plus, the population base is larger in our service area than for either of the two prior projects. The Guidelines for Growth do not address MUA.

Some chiropractic practitioners have estimated that approximately 5% of patients with chronic pain may be candidates for MUA. If that estimate is correct, approximately 162 patients already being seen at Spinal Health Care Associates in 2012 may be candidates for MUA. If that is correct, the Applicant's estimate of 130 patients the first year appears reasonable.

As stated in the application, this procedure cannot be performed in an office setting. Licensed facilities (hospitals, ASTCs) normally do not approve Doctors of Chiropractic for admitting privileges. Therefore, specialty ASTCs are required for these procedures. Please see a restatement from pages 10 and 11 of the application, which answers this question:

"MUA procedures must be performed in a designated area where anesthesia is provided. To do that, a facility must meet the basic needs of a proper room, life support, room for the movement of the physicians involved in the procedure, as well as room for the nursing staff and the anesthesiologist. The designation of a "clean room" can be used in this case since this procedure does not require a sterile environment. The Applicant believes that such procedures should be administered in a licensed, regulated environment by licensed, regulated physicians to ensure proper protocols are followed, thereby ensuring that the procedures are performed correctly, keeping in mind the patients' health.

"While MUA procedures could have been conducted in a physician's office in the past, such is not desirable for the reasons stated above. There is no current licensure designation for a clinic in which to perform MUA procedures, only. However, according to the Board for Licensing Health Care Facilities, Department of Health, such procedures could be performed in a "specialized" ASTC. Therefore, the Applicant is applying for a specialized ASTC, limiting the procedures to be performed to MUA, only.

"A decision by the Board of Chiropractic Examiners would have the effect of limiting MUA procedures to certified facilities, so "in-office" procedures are a thing of the past. On February 21, 2008, the Board of Chiropractic Examiners adopted the following position statement:

"A licensed Tennessee chiropractor may provide chiropractic services to a patient who is under anesthesia if and only if:

- (1) The chiropractic physician has received certification from an institution accredited by the Council on Chiropractic Education (CCE) and pursuant to a course of study recognized by the National Manipulation Under anesthesia (MUA) Academy of Physicians and/or the International MUA Academy of Physicians; and
- (2) The anesthesia is administered in a facility properly equipped and certified as required by law to administer anesthesia; and
- (3) The anesthesia is administered by – and the anesthetized patient is at all times monitored by – an anesthesiologist or other healthcare professional who is legally qualified to perform and monitor anesthesia.”

“This Applicant will comply with this position statement.”

Please indicate if the proposed project will be providing manual procedures in a clean environment as opposed to traditional ASTC operative procedures in a sterile environment.

Response: As stated in both the Application and the ASTC Specific Criteria, only a clean environment is required for MUA.

Please clarify if this proposed project is associated with existing MUA clinics in Nashville and Knoxville.

Response: No.

Please clarify if other chiropractors will have access to this ASTC to conduct MUA procedures.

Response: We plan to offer the services of our ASTC to local physicians (M.D.s, D.O.s, and D.C.s) who have been trained and certified in MUA.

5. Section B, Project Description, Item II A

The purchase of a C-Arm in the amount of \$40,000 is noted. Please indicate what type of equipment this is and its importance in conducting (sic) MUA procedures. Is there a separate patient charge for the use of this equipment?

Response: A C-Arm is a fixed, permanently-installed flourosopic system. The imaging system allows easy positioning with adequate space to work around and a wide range of motion. The C-arm will be utilized for injection placement for MUJA procedures. It is not utilized during more progressive MUA procedures. There is no separate charge.

6. **Section B, Project Description Item III (Plot Plan) and Item IV (Simple Drawing)**

The applicant notes \$100,000 for construction cost in the narrative but places “possible renovation” in parenthesis in the amount of \$100,000 in the Project Costs Chart. Please clarify.

Response: The site for this ASTC currently exists. Therefore, “construction” – in the traditional sense of the word – is not required. However, the space will have to be renovated. The Project Costs Chart does not have an entry for “renovation.” Please see revised Project Costs Chart (page 28-R) without the word “possible.”

The floor plan of the proposed site is noted. Please explain why the simple line drawing is titled “Cordova Pain Management, Ambulatory Surgery Center Floor plan”.

Response: The architect who drafted the buildout plan for this ASTC has prepared interior design and buildout changes for the Applicant’s Owner in the past. The earlier project by the architect was listed under one of the Owner’s d/b/a’s (Cordova Pain Management), so the architect merely utilized the same name for this project. Please see a replacement floor plan (*Supplemental B.IV*) without the d/b/a name.

7. Section C, Need, Item 1.a (Service Specific Criteria-ASTC)

Please clarify how the applicant can appropriately address any of the ASTC specific criteria while it is unknown if Medicare, TennCare and commercial insurance reimburse for MUA services.

Response: We have been informed that Medicare and commercial insurance do reimburse for these procedures, and that TennCare reimburses for some procedures but maybe at a discounted rate. Further, there are no reimbursement questions in the ASTC Specific Criteria.

8. Section C, Need, Item 1.a (Service Specific Criteria-ASTC (4))

Please indicate when the applicant projects to perform a minimum of 800 cases per room.

Response: MUA is such a specialized procedure, we are not aware if we will ever have 800 MUA cases per year. There are no known adopted formulae that determine the number of MUA procedures needed by the general population. As stated earlier, some chiropractic physicians estimate that approximately 5% of patients with chronic pain would benefit from MUA. The Applicant's patient base indicates over 160 patients would qualify for such procedures. If other local physicians opt to utilize this service at our ASTC, we could reach the goal of a minimum of 800 cases per room. However, we do not know if and when that will happen. What we do know is that there is a need for MUA, and the closest facility providing such is over 220 miles away.

9. Section C, Need, Item 4.B.

Please indicate if there are any special needs of the service area population other than overmedicating patients with painkillers. How will the long-range plans of the facility take into consideration the special needs identified in the service area population?

Response: The biggest indicators for the need for MUA include chronic neck and back pain, failed surgeries, and the fact that, for too long, many patients have relied on medication in their attempts to alleviate chronic pain. MUA provides a viable alternative for the service area population to overmedicating. The absence of MUA services in the service area is the only special need known at this time.

10. Section C, Need Item 5

The applicant mentions Robert C. Gordon, D.C. has trained all the doctors in this proposed project. Please verify Robert C. Gordon is licensed in the State of Tennessee as a D.C.

Response: Dr. Gordon is not licensed to practice in Tennessee, nor does he need to be, as he does not practice in Tennessee. He merely trains licensed physicians in this procedure, and has trained hundreds of physicians in several states over his career. Dr. Gordon trained all of the chiropractors and other physicians who were associated with the two prior MUA ASTCs that are now licensed and in operation in Tennessee.

11. Section C, Economic Feasibility, Project Costs Chart

There is a calculation error in the Project Costs Chart. Please correct and resubmit.

Response: Please see Replacement page 28.

12. Economic Feasibility, Item 2, Project Funding

The letter from First Tennessee verifying \$200,000 to implement the proposed project is noted. However, the applicant plans to maintain an average monthly balance sufficient to serve as cash reserves. Since the 80% of the projected revenue is TennCare and there is a probability of a large number of charity care, please provide additional documentation of adequate cash reserves to cover the balance and any additional unforeseen projects costs.

Response: As previously stated, TennCare does reimburse for most MUA procedures, the only exception of which we are aware involves BCBST patients regarding spinal manipulation. To our knowledge all other MCOs reimburse for all procedures, and BCBST reimburses for all procedures other than spine. Therefore, there should be no need for additional cash reserves.

The Spinal Healthcare Associates P.C. Balance Sheet indicates a loan to Shareholder in the amount of \$586,685.39. Since this is a large percentage of current assets, what is the purpose of this loan?

Response: By the time of filing these Supplemental Responses, this loan will have been paid. The building was owned by two individuals at the time of filing this application. At present, the debt of one of the individuals will be paid by the transfer of ownership of the building to the other individual. In effect, Dr. Wooster now owns the building outright, and the debt of Dr. Coleman is released.

13. Economic Feasibility, Item 3

Please compare the renovated cost per GSF to other ASTC projects for Years 2009-2011 using the applicant's toolbox on HSDA's web-site located at http://tennessee.gov/hdda/applicants_tools/app_tool_box.shtml

Response: Please see Replacement Page 27.

14. Economic Feasibility, Item 4, Projected Data Chart

The applicant has stated in the application one fee will be charged to patients. Please explain how this fee is calculated.

Response: As contained in all other MUA applications that have been filed for CON in Tennessee, this fee seems to be the usual and customary rate. There is no usual and customary rate for MUA in the Memphis area, so we used the same rates already seen and approved by the HSDA in both the Nashville and Knoxville facilities. As we made our expense projections, the end result was that the fee appeared to be reasonable.

A Medical Director is listed on the Projected Data Chart at a cost of \$210,000 per year. Please indicate the name of the Medical Director and his/her background.

Response: David Crawford, M.D. will be our Medical Director. However, he will not be paid the amounts shown. Please pardon the typo. The amount provided includes the total amount that we anticipate being paid to all medical practitioners, including the M.D., the anesthesiologist, and nurse practitioners. Please see Replacement Page 33.

There is an error in the amount in the Year 2 column under insurance. Please correct and resubmit a replacement page.

Response: Please see Replacement Page 34.

15. Section C., Economic Feasibility, Item 5

The statement clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy and anesthesiologists will bill for their own perspective services is noted. Please indicate the estimated amount these providers will charge outside the MUA procedure. Also, if the applicant accepts a charity case does that guarantee the above professionals will not bill?

Response: This statement was in error. We anticipate that the gross charge of \$15,000 per patient will be a global charge, and professionals will not bill outside the MUA procedure. Please see replacement pages 35 and 36.

16. Section C, Economic Feasibility, Item 6.B

Please indicate the top 10 projected CPT reimbursed procedures for this proposed project.

CPT Code	Brief Description	Estimated bundled or global billable amount
21073	TMJ	12,000
22505	Spine any region	8,000
23700	Shoulder	9,000
24300	Elbow	12,000
25259	Wrist	15,000
26340	Finger	12,000
27194	Pelvic	15,000
27275	Hip	9,000
27570	Knee	9,000
27860	Ankle	9,000

The applicant has provided some common CPT codes. Please complete the following table in regards to BlueCare and AmeriChoice:

CPT Code	Description	Covered by AmeriChoice? Y/N	Covered by BCBST? Y/N
22505	TMJ	Y	N
27275	Hip	Y	Y
23700	Shoulder	Y	Y
27194	Pelvis	Y	Y
24300	Elbow	Y	Y
26340	Finger	Y	Y
27870	Ankle	Y	Y
27860	Ankle	Y	Y

Response: The above charts are completed. Please note that we do not plan to perform 27870, as this is an open surgery of the ankle. The submission of this CPT code was a typo.

Also, please note that the dollar amounts in the top chart of this question reflect the Medicare Allowable Amount. The dollar amounts on the BlueCare chart (*Supplemental A.12.3*) reflect the negotiated rates between BlueCare and the Applicant. These rates will differ.

17. Section C, Orderly Development, Item 1

Please indicate if there are any transfer agreements with any hospitals. If so, please list those hospitals.

Response: The Applicant's ASTC has no transfer agreements with area hospitals. However, the hospitalists at Baptist Memorial Medical Group will admit patients meeting inpatient criteria for patients of the Spinal Health Care Associates. Please see *Supplemental C.OD.1.*

Please indicate if practitioners who will provide care at the proposed MUA ASTC will have admitting privileges at area hospitals. If so, please list those hospitals.

Response: All medical doctors (both M.D. or D.O.) who will provide any services at our ASTC will have to have admitting privileges at area hospitals. As we do not have a list of these personnel, we do not have a list of the specific hospitals.

18. Section C, Orderly Development, Item 4

Please provide a copy of the license of providers who have been identified to provide clinical services in this project.

Response: *Supplemental C.OD.4* contains copies of all licensed personnel at Spinal Health Care Associates.

19. Section C, Orderly Development, Item 5

The statement “certain waivers will be requested as no operative surgical procedures will take place” is noted. Is the applicant referring to two ASTC regulations that were waived during the Board for Licensing Health Care Facilities meeting on May 12, 2009 for MUA Medical Clinics in Brentwood and Knoxville? If so, please explain.

Response: Yes. The quoted statement was in response to a question regarding licensure, and the Applicant will request the same waivers (licensure waivers) requested by and approved for the two existing MUA specialty ASTCs in Tennessee, since the Applicant will be providing the same service.

20. Section C, Orderly Development, Item 8

The Tennessee Department of Licensure Practitioner Profile Data information indicates there was an above settlement reported on January 23, 2008 for Rock Wooster, DC. Please describe this above average settlement.

Response: A patient with chronic neck pain was adjusted three times by Dr. Wooster, and later alleged that Dr. Wooster contributed to rupturing a disc in his neck. The Attorneys settled the case rather than going through a protracted and costly trial. The Applicant is aware of T.C.A. §63-51-105 and the stated limits of what constitutes an "above average settlement." However, the Applicant is unaware of the criterion utilized by the legislature to arrive at those stated limits. Please note that Dr. Wooster has been a licensed chiropractor since September, 1982.

Also, there appears to be adverse license actions associated with Rock Wooster. Please provide a copy of the board order dated March 31, 2011 from the Department of Health Licensure web-site. The address of the web-site is

http://health.tn.gov/DisciplinaryExclusion/boardorder/display/1108_830_033111

Response: There is only one adverse license action. Dr. Wooster, a licensed chiropractor for now over 30 years, went to a continuing education seminar at a college in January, 2010, believing the seminar to be approved by the Board of Chiropractic Examiners for continuing education. In March, 2011, Dr. Wooster was notified that the January, 2010 seminar was not approved and would not count toward his continuing education hours. He paid the usual and customary fine, and attended an approved seminar. It is noteworthy that, had the Board notified Dr. Wooster in early 2010 of such disapproval when he reported his attendance, he would have had ample time to attend an approved seminar during that calendar year. The two-page Board order involving continuing education is included as *Supplemental C.OD.8*.

According to the Bank Records provided, it appears Chiropractic Physicians Jason Coleman and Jeffrey Becker are associated with the proposed project. Please provide web-based verification of their licenses and copies of any board orders by the Tennessee Board of Chiropractic Examiners.

Response: Dr. Rock Wooster and the two mentioned chiropractors used to work out of the same office practice. Dr. Coleman and Dr. Becker were independent contractors who utilized Dr. Wooster's office to provide chiropractic procedures to their respective patients. Neither of these two mentioned chiropractors are associated with this project, nor do they have any affiliation with this project.

Dr. Coleman continues to provide chiropractic to his patients at Owner's office, and a copy of his license is included in *Supplemental C.OD.4*. Dr. Coleman, however, is not a five percent (5%) or more owner of the project. Dr. Becker no longer practices at Dr. Wooster's office.

21. Section C, Orderly Development, Item 12

The applicant mentions MUA facilities in Knoxville and Nashville. Please indicate if these facilities are contracted with TennCare MCOs and Medicare for MUA services.

Response: There is no item 12 in the Orderly Development section of the application, and it is assumed this question is for item A.12. The Applicant mentions the MUA facilities in Knoxville and Nashville early in the CON application (Item A.12, Item B.I.A and other places) as they are the only facilities providing similar services to those proposed by the Applicant. The CON application specifically requests information on similar facilities and/or services.

However, the Applicant has no affiliation or common ownership with these two facilities, and has no direct knowledge as to whether or not these facilities are contracted with TennCare MCOs and Medicare for MUA services. Therefore, the Applicant cannot answer this question for those facilities at the present time. Once JARs are filed by these facilities with the State, such information should be available.

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As of January 29, 2013 at 4:30 p.m. we have processed business entity filings received in our office through January 29, 2013 and annual reports received in our office through January 29, 2013.

Search:						1-1 of 1
Search Name: SHELBY COUNTY PAIN CLINIC				<input checked="" type="radio"/> Starts With <input type="radio"/> Contains		
Control #:						
Active Entities Only: <input type="checkbox"/>				<input type="button" value="Search"/>		
Control #	Entity Type	Name	Name Type	Name Status	Entity Filing Date	Entity Status
000292714	CORP	SHELBY COUNTY PAIN CLINIC TENNESSEE	Assumed	Active	03/30/1995	Active
						1-1 of 1

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February 11, 2013
12:55pm

From: SPINAL HEALTHCARE

901 751 0332

12/20/2012 09:41

#567 P.002/002


STATE OF TENNESSEE
DIVISION OF HEALTH RELATED BOARDS

EXPIRATION DATE: 03/31/2015
LICENSE NO.: DC0000002633
RENEWAL NO.: 608660

THIS IS TO CERTIFY THAT:
JAMES T WILSON II
IS A DULY LICENSED
CHIROPRACTIC PHYSICIAN
IN THE STATE OF TENNESSEE AS REQUIRED BY THE
TENNESSEE CODE ANNOTATED.

Rosemarie OHO
DIRECTOR, HEALTH RELATED BOARDS

J Wilson DC
SIGNATURE:



March 27, 2008

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Thank you for contacting the American Medical Association (AMA) with your coding inquiry regarding CPT code 22505.

From a CPT coding perspective, Category I CPT codes describe a procedure or service identified with a five-digit numeric CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations.

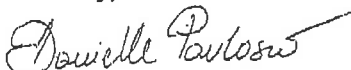
In developing CPT code 22505-*Manipulation of spine requiring anesthesia, any region*, CPT code 23700-*Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)*, and CPT code 27275-*Manipulation, hip joint, requiring general anesthesia*, as with all new and revised CPT codes, the CPT Advisory Committees and the CPT Editorial Panel require:

- ▶ that the service/procedure has received approval from the Food and Drug Administration (FDA) for the specific use of device or drugs;
- ▶ that the suggested procedure/service is a distinct service performed by many physicians/practitioners across the United States;
- ▶ that the clinical efficacy of the service/procedure is well established and documented in the United States per review literature;
- ▶ that the suggested service/procedure is neither a fragmentation of an existing procedure/service nor currently reportable by one or more existing codes; and
- ▶ that the suggested service/procedure is not requested as a means to report extraordinary circumstances related to the performance of a procedure/service already having a specific CPT code.

Therefore, based upon the above information and in response to your specific question, Category I codes do not represent experimental or emerging technology.

Thank you for your inquiry, and I hope this information is of assistance to you.

Sincerely,



Danielle Pavloski
Director

This is a category mandated by HB 2600.

The law defines investigational or experimental services as any service or device for which there is early developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care. This definition was incorporated into the rule. If the AMA has assigned a Category 1 CPT Code, then this procedure is considered to be consistent with contemporary medical practice and is therefore not experimental or investigational.

Manipulation Under Anesthesia (MUA)

A Conservative Treatment Alternative for Chronic Biomechanical Dysfunction Patients

Spinal manipulation under anesthesia is a procedure that primarily originated with the osteopathic profession and has been utilized for the treatment of spinal pain since the late 1930's.¹ Documentation regarding the success and value of manipulation under anesthesia has been recorded in the osteopathic literature since 1948 when Clybourne reported in the Journal of American Osteopath Assoc. a success rate of 80-90% which has been maintained to this day.² In the last two decades, the emphasis regarding manipulation in osteopathic education has greatly decreased. Therefore, the osteopaths that had been adequately trained in manipulation are coming to the close of their careers or have retired. Because of the need for continuance of this procedure, the focus for the performance of spinal manipulation under anesthesia has now shifted to chiropractic and their expertise in spinal manipulative skills.

Indications for MUA

Spinal manipulation under anesthesia is a procedure that is intended for patients that suffer from sometimes acute, but mostly chronic musculoskeletal disorders in conjunction with biomechanical aberrancies. These individuals have also been minimally responsive to previous conservative therapy.^{3,4} Etiology of their pain can be disc bulge/herniation, chronic recurrent sprain/strain, failed back surgery, myofascial pain syndromes in conjunction with those listed below. The procedure is extremely beneficial for the patient that has muscle spasm accompanied with pain and terminal joint range of motion loss. These types of patients typically respond well to manipulation/physical therapy/exercise, but their relief may only be temporary (days to weeks). To ensure good results with a procedure of this type, one of the most important considerations is patient selection. The indications/contraindications being adhered for this procedure are as follows:^{5,6,7}

¹ Greenman, P., DO: Manipulation with the patient under anesthesia. JAOA 1992;92:1159-1169.

² Clybourne, HE. Manipulation of low back region under anesthesia. J AM Osteopath Assoc. 1948; Sept: 10-11.

³ Francis, R., DC: Spinal manipulation under anesthesia: a chiropractic approach in the hospital setting. Amer. Assoc. J Chiropractic 1989; 12:39-41.

⁴ Kirkcaldy-Willis and C. Burton: Managing low back pain. Churchill Livingstone, 1992:294-95.

⁵ Francis, R., DC: Manipulation under anesthesia. Amer. Chiropractor 1991; 12:24-27.

⁶ Greenman, P., DO: Manipulation with the patient under anesthesia. JAOA 1992;92:1159-1169

⁷ Kessler-Randolf: Management of common musculoskeletal disorders. Harper & Row 1987; 132-33.

Indications

1. Bulging, protruded, prolapsed or herniated disc without free fragment and are not surgical candidates.
2. Frozen or fixated articulations from adhesion formation.
3. Failed low back surgery.
4. Compression syndromes with or without radiculopathies caused from adhesion formation, but not associated with osteophytic entrapment.
5. Restricted motion, which causes pain and apprehension from the patient, but manipulation is the therapy of choice.
6. Minimally responsive to manipulation and adjustment when they are the therapy of choice.
7. Minimally responsive pain, which interferes with the function of daily life and sleep patterns, but which fall within the parameters for manipulative treatment.
8. Minimally responsive muscle contracture which is preventing normal daily activities and function.
9. Post-traumatic syndrome injuries from acceleration/deceleration or deceleration/acceleration types of injuries which result in painful exacerbation of chronic fixations.
10. Chronic recurrent neuromusculoskeletal dysfunction syndromes, which result in a regular periodic treatment series, that are always exacerbations of the same condition.
11. Neuromusculoskeletal conditions that are not surgical candidates but have reached MMI, especially with occupational injuries.

Contraindications

1. Any form of malignancy.
2. Metastatic bone disease.
3. TB of the bone.
4. Acute bone fractures.
5. Direct manipulation of old compression fractures.
6. Acute inflammatory arthritis.
7. Acute inflammatory gout.
8. Uncontrolled diabetic neuropathy.
9. Syphilitic articular or periarticular lesion.
10. Gonorrheal spinal arthritis.
11. Advanced osteoporosis (as indicated diagnostically).
12. Evidence of cord or caudal compression.
13. Osteomyelitis.
14. Widespread staph/strep infection.
15. Sign/symptom of aneurysm.
16. Unstable spondylolysis.
17. Morbid obesity (ASC class III)

Post Manipulation Under Anesthesia Rehabilitation

Introduction

Manipulation Under Anesthesia (MUA) is usually performed on acute or chronic cases. MUA is performed on acute cases when the symptoms prevent the use of more conventional management consisting of manipulation and adjunctive procedures. MUA is performed on chronic cases when all other forms of conservative management have been performed without resolution.

Acute used in treatment time protocols applies to the first 6 weeks of case management. This usage must not be confused with the acute inflammatory reaction to injury which usually last from 24 to 72 hours assuming no complications or aggravations. In effect, acute as used in treatment time protocols is Stage I and II of the healing response. Stage I and II may span a time frame of 6 weeks assuming no complications. The case management goal would be to shorten the time of Stage I and II presentations as much as possible. This will maximize the healing potential. If effective intervention of Stage I and II is interfered with, this will not only complicate the case, but increase the time frame and the possibility of the injury becoming chronic.

Spinal manipulation has been shown to be an effective management tool in the treatment of acute low back pain. Patients do not typically seek out this type of treatment. The larger percentages of these musculoskeletal conditions are low back pain. They typically recover within 6 weeks. This gives the typically patient the perception that their condition will resolve with minimal time and treatment. They often depend on more conventional methods such as bed rest, heating pads, analgesic ointments and over the counter medications. This increases the treatment time and complicates the case. Fifteen to twenty percent of these cases are unresponsive and fail to resolve often resulting in chronic conditions.

Chronic in treatment time protocols indicates a persistence beyond 18 weeks. Chronic by definition, means not self limiting. A chronic injury can be an acute or overuse injury treated improperly, or ignored. Repeat irritation or aggravation with a low level inflammatory process can lead to local accumulation of scar tissue and granular tissue which remains vascular and supportive of the growth of pain sensitive nerve endings. This tissue is very painful, and proliferates as irritation continues. Many reflex and degenerative effects occur in the affected area. Some of these are: a gradual loss of ligamentous integrity resulting in weaken or stretched ligaments, compartments or capsules, loss of proprioception from the joints, ligaments and capsules, excessive range of motions, reflex splinting or weakness of the surrounding muscles, recurrent pain, and early onset of DJD or DDD. The presentation of the symptoms may be episodic or progressively unremitting. The symptoms may appear as chronic but the so call 'chronic' presentation is really a sequence of acute episodes over a

pre-existing weakness or injury. The doctor must be alert to this. The treatment plan must change back to an acute inflammatory response when such aggravations occur. The ultimate goal of treatment must be to get the individual patient back into their profession without or only minimal residuals that are not limiting from a biomechanical standpoint.

Considerations

Manipulation under anesthesia often results in the restoration of the lost integrity from chronicity to an area. Why is this concept so important in the rehabilitation of the chronic patient? Often rehabilitation programs focus to functional restoration of the injury as opposed to the correction. These are to separate and distinct types of rehabilitation. This is why post MUA or post surgery rehabilitation often fails. Hence, the post MUA rehabilitation program must consider functional restoration of the correction.

Age, body type and sex are additional considerations of all rehabilitation programs. The neurological system of the human being interprets data differently before and after about age thirty-five. A rehabilitation program on a patient younger than age thirty should focus about 65 % of the functional restoration to the injured part and 35% to the rest of the body. Eg. If your where designing a rehabilitation program for a 30 year old patient with a low back injury, 65 % of the rehabilitation would be focused to the lower body and 35% to the upper body. If this same patient were 40 years of age 35% of the rehabilitation would be focused to the lower body and 65% of the rehabilitation would be focused to the upper body. Another consideration of age is muscle recruitment verses hypertrophy. Men over the age of about 65 years of age usually recruit muscle. One observation of this process is the development of "chicken legs". Women and ectomorphic men also recruit muscle. Mesomorphic and endomorphic men hypertrophy muscle.

Concepts

The differences of acute verses chronic post MUA rehabilitation. In the acute post MUA patient collagen repair begins about the 5th day and peaks over the next 21 days. MUA during this time frame will maximize collagen organization minimizing the scar tissue. The "window of opportunity" in acute conditions is between the third to fourteenth week. Manipulation and mobilization continue to maximize tissue organization minimizing scarring. This is the period where the patient is transitioned to active care. Observation of the patient's progress at this treatment period is paramount. The health care provider must exert caution to prevent the patient from reinjury as a result of to quick a progression. If successful active care can now begin. The goal is to establish functional restoration which includes, speed, strength, proprioception, endurance, flexibility and pain free range of motion. The rehabilitation is performed until the patient reaches seventy five percentile relative to age and sex or until their progress

reaches a plateau. This can be determined by either establishing a baseline and comparing the values to normative data, or by testing and uninjured part of the individual. Eg. Shoulder elevation is 80% of knee extension.

In the chronic patient scarring and adhesions were probably present prior to the MUA procedure. The patient as a result has functional deficit consisting of compromised biomechanics with compensatory reactions, abnormal learning patterns, muscle imbalances, shallow breathing and decreased proprioception. The chronic patient often has a more complicated deconditioning. The MUA will correct the biomechanics. The rehabilitation then must be initially focused to neuromuscular reeducation, balancing the muscles, restoring breathing patterns and increasing the proprioception. Once this is accomplished the patient then can speed, strength, flexibility and endurance training. The rehabilitation should be performed until the patient based on age and sex reaches 75% or until their progress reaches a plateau. Once again this can be determined by establishing a baseline and comparing values to normative data, or by testing an uninjured part of an individual.

Precaution to Rehabilitation

All patients should complete a Par Q Form prior to beginning any rehabilitation program. If two or more of the responses are positive medical clearance should be obtained.

ACUTE POST MUA SPINAL REHABILITATION

The focus of this type of rehabilitation is to maintain a balance of flexibility, strength, proprioception and endurance. Endurance training increase the aerobic potential decreasing stress levels by reducing the heart rate. Rehabilitation also promotes self-confidence. Patients who participate in supervised rehabilitation programs are found to have increased strength, decreased body fat, decreased subjective pain levels and increased compliance, all of which are related to increased psychological benefits.

MUA with proper rehabilitation techniques that employ strength and stabilization, above and below the injured segment, allow healing with improved biomechanical function, soft tissue strength and stability.

Initially the patient will be treated with MUA procedures. The patient will then be adjusted to maintain the biomechanics. Adjunctive procedures such as ice and interferential can be used for symptom control. Interferential therapy will transition from the "High" setting in stage I to the "High/Low" setting in stage II. Postural exercises should be performed to mirror image. Nutrition should be recommended to enhance the rehabilitation process. McKenzie exercises and stretching within pain free range of motion may be used to limit the effects of deconditioning. These can be performed at home by the patient. The exercise

progression should move from passive, to passive assistive, to passive resisted, to active resistive. The progress is based on patient comfort. The exercise are performed in the pain free range of motion. Massage therapy can be performed to help the progression and promote fiber organization further minimizing the scar tissue. Proprioceptive train should be performed as early as possible. This can be performed on wobble boards such as baps. Submaximal isometrics can now be started. PNF can be performed to patient comfort. The program now expand to full performance in stage III. The patient should come into the office and assessment performed establishing the baselines. The patient should then warm up with stretching exercise followed by kinetic activities such as aerobic exercise. Endurance is then improved through aerobic training, followed by protocols to improve whole body condition and agility. The endurance training should be performed three times a week for 30 to 40 minutes on three to four different devices. The maximum aerobic benefit is achieved between the 2nd and 40th minute. The aerobic benefit declines significantly after 40 minutes. Each day the devices should alternate. This prevents the body from adapting to the training program and maximizes the aerobic potential. Eg. Day one: treadmill for ten minutes, stepper for ten minutes, elipical walker for ten minutes., Day two: stepper for ten minutes, elipical walker for ten minutes, stationary bike for ten minutes. Proprioceptive training should now be performed on wobble boards. The patient should be able to stand on wobble boards for two minutes with increasing difficulty each session. The patient should then strength train with either thera bands or weight training devices. Eg. free weights Exercise protocol should be specific to the patient's condition. Eg. Oxford for work conditioning. The patient stretch following completion of the program, and ice down if necessary. It is crucial that there be a detailed communication between the patient and the supervised rehabilitation practitioner about the different types of pain the patient may be experiencing. The patient needs to understand that the perception of fatigue and/or muscle soreness, secondary to exercise, is unrelated to the initial or pathologic pain. The patient should be encouraged to work through fatigue or soreness but should stop exercising if initial symptoms increase. After the appropriate initial response of the patient to exercise, the intensity of the exercise should be consistently progressed to facilitate increasing tissue tolerance and stability. There are three major ways to progress exercise. The first is to alter the position of the patient in which the exercise is performed. Position should eventually be progressed to weight bearing exercise, since humans function in this posture. Exercises should encompass activities that replicate the patient's individual needs for work and other activities of daily living. Second, the amount of resistance can be modified. Resistive movements should dictate the amount and intensity of the patient's individual work or activity requirements. Third, the type of muscle contraction used in exercise can be modified by increasing or decreasing the tension produced with the number of repetitions performed. Other considerations in exercise progression include repetition number, speed of movement, length and number of resting intervals, and training frequency. Frequency and progression should be as tolerated, with each treatment progressing if the prior dosage was appropriate.

The rehabilitation specialist must rely on periodic functional capacity assessment to document changes in mobility, strength and endurance, as well as subjective pain complaints, in order to progress in the treatment program. This program should be continued until the patient reaches seventy five percentile or their progress reaches a plateau.

CHRONIC POST MUA SPINAL REHABILITATION

MUA in the chronic case restores the biomechanics and soft tissue integrity. The focus of this type of rehabilitation is to restore normal breathing and learning patterns, balance the muscles, increase proprioception, flexibility, strength, and endurance. Chronic Post MUA rehabilitation begin in stage III.

Initially the patient will be treated with MUA procedures. The patient will then be adjusted to maintain the biomechanics. Adjunctive procedures such as ice and interferential can be used for symptom control. The interferential therapy will be performed at the "High/Low" setting. Passive care will only be performed on an as need basis. Respiration is probably the most important of all movement patterns. Faulty breathing usually occurs with chronic conditions. If breathing is not normalized no other movement pattern can be. Breathing can facilitate or inhibit the motor system. Shallow breathing is an example of faulty breathing. Respiration is automatic and difficult to influence. To correct it you must be conscious of it. The purpose of treatment is to facilitate the genetic motor program of movement allowing ideal use of the muscles resulting in core stability of the spine and pelvis. Abnormal muscle patterns can be detected and analyzed using methods described by Janda. Chronic condition often exhibit "Tightness weakness". Eg. Failed squat test. These muscles need to be stretched and balanced. Eg. Abdominal hollowing and bracing. This can be accomplished with stretching techniques. Eg. PNF or contract and relax. Postural exercise should be performed to mirror image. McKenzie exercises and stretching within pain free range of motion may be used to limit the effects of deconditioning. Nutrition should be recommended appropriate to enhancing the rehabilitation process. These can be performed at home by the patient. The patient should now have assessment performed establishing the baselines. Proprioceptive training can be performed on devices such as wobble boards or gym balls or any combination of both devices. The patient should be able to maintain his balance for two minutes per session with each session becoming increasingly more challenging. Once the patient has regained normal breathing patterns, achieved muscles balance and proprioception has improved, more comprehensive rehabilitation can be added to the program. The exercise progression should move from passive, to passive assistive, to passive resisted, to active resistive. The progress is based on patient comfort. The exercise are performed in the pain free range of motion. Massage therapy can be performed to help the progression and promote fiber reorganization of the scar tissue. The patient should then warm up with stretching exercise followed by kinetic activities such as aerobic exercise. Endurance is then improved through aerobic training, followed by protocols to

improve whole body condition and agility. The endurance training should be performed three times a week for 30 to 40 minutes on three to four different devices. The maximum aerobic benefit is achieved between the 2nd and 40th minute. The aerobic benefit declines significantly after 40 minutes. Each day the devices should alternate. This prevents the body from adapting to the training program and maximizes the aerobic potential. Eg. Day one: treadmill for ten minutes, stepper for ten minutes, elipical walker for ten minutes., Day two: stepper for ten minutes, elipical walker for ten minutes, stationary bike for ten minutes. Proprioceptive training should now be performed on wobble boards. The patient should be able to stand on wobble boards for two minutes with increasing difficulty each session. The patient should then strength train with either thera bands or weight training devices. Eg. free weights Exercise protocol should be specific to the patient's condition. Eg. Oxford for work conditioning. The patient stretch following completion of the program, and ice down if necessary. It is crucial that there be a detailed communication between the patient and the supervised rehabilitation practitioner about the different types of pain the patient may be experiencing. The patient needs to understand that the perception of fatigue and/or muscle soreness, secondary to exercise, is unrelated to the initial or pathologic pain. The patient should be encouraged to work through fatigue or soreness but should stop exercising if initial symptoms increase. After the appropriate initial response of the patient to exercise, the intensity of the exercise should be consistently progressed to facilitate increasing tissue tolerance and stability. There are three major ways to progress exercise. The first is to alter the position of the patient in which the exercise is performed. Position should eventually be progressed to weight bearing exercise, since humans function in this posture. Exercises should encompass activities that replicate the patient's individual needs for work and other activities of daily living. Second, the amount of resistance can be modified. Resistive movements should dictate the amount and intensity of the patient's individual work or activity requirements. Third, the type of muscle contraction used in exercise can be modified by increasing or decreasing the tension produced with the number of repetitions performed. Other considerations in exercise progression include repetition number, speed of movement, length and number of resting intervals, and training frequency. Frequency and progression should be as tolerated, with each treatment progressing if the prior dosage was appropriate.

Once again rehabilitation specialist must rely on periodic functional capacity assessment to document changes in mobility, strength and endurance, as well as subjective pain complaints, in order to progress in the treatment program. This program should be continued until the patient reaches seventy five percentile or their progress reaches a plateau.

POST MUA EXTREMITY REHABILITATION

ACUTE or CHRONIC

The main goal of extremity rehabilitation must be maximum functional restoration in the shortest period of time. Rehabilitation should begin at the same time as treatment of the injured part. The treatment and rehabilitation should blend together as one. The goal is not to speed up the healing process but to do everything possible not to slow it down. MUA of the acute or chronic extremity restores the integrity of the soft tissues, the nerve supply, flexibility and range of motion. The focus is strength, flexibility, ROM, endurance, muscle balancing and proprioception.

Initially breathing patterns should be assessed. Faulty breathing can occur with acute or chronic extremity conditions. If breathing is not normalized no other movement pattern can be. This needs to be addressed first. The next step should be the assessment of abnormal muscle patterns such as "Tightness Weakness". Techniques such as PNF can be performed. Assessment and baselines can now be established. The non-injured side should begin an aggressive rehabilitation program. This will lead to neurological "Crossover" effect improving the injured side. The injured side can now be transitioned to more focused active care. The exercise progression should follow the standard orthopedic protocol mentioned above. This should be performed in the pain free range of motion. This can initially be performed with thera band, transitioning to free weights, to weight training stations. The exercise protocols can be appropriate to the patient. Eg. Oxford for work conditioning. Kinetic activities as described above should be performed to increase endurance and enhance the aerobic potential. The typical day would consist of patient assessment, followed by "warming up" with stretching and aerobics, proprioception training, weight training, stretching and ice if necessary to "cool down". Manipulation, massage and interferential or appropriate modality should be performed on an as need basis. This should continue until the patient reaches seventy five percentile or their progress reaches a plateau.

These cases should be documented by a combination of outcome assessment measures. This can be accomplished by patient generated responses to assessment forms, Eg. Oswestry Low back Pain Questionnaire, and by doctor generated testing. Eg. J-Tech Functional demand testing.

Home Programs

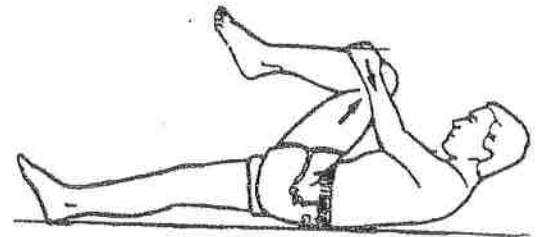
All patients are given a specific home exercise program to enhance the rehabilitation process. This program should consist of specific written exercises in a format that allows easy visualization and understanding. The exercises should be taught by a certified specialist so the patient fully understands and is able to perform the exercises as prescribed before leaving the office.

Patient: Back Stretch

Start Date:

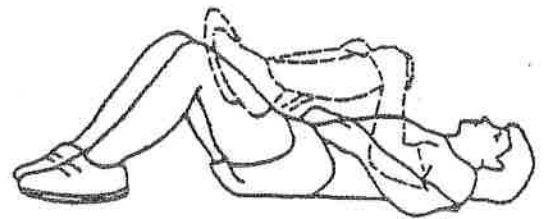
1. Knee to Chest 2 - 10 reps

Lie with the legs straight as shown. Pull one knee in to the chest until a comfortable stretch is felt in the back and hip area. Hold for 5 seconds, repeat 10 times with each leg.



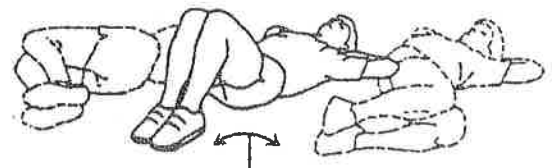
2. Knee to Chest, Double - 10 reps

Lie on your back. Bring both knees to your chest. Clasp your hands around both knees and pull gently until you feel a stretch. Hold 5 seconds. Repeat 10 times.



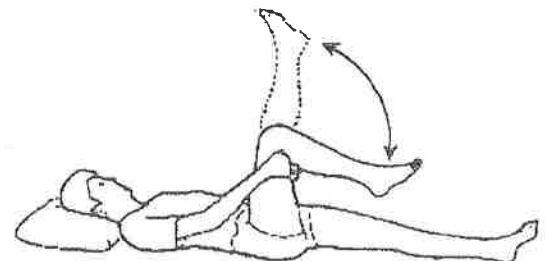
3. Pelvic Rotation - 10 reps

Lie on your back with your knees bent, feet flat on the floor, and your hands behind your neck. Slowly lower both bent knees to the floor, to the right, and then to the left. Keep the motion as smooth as possible. Do not rush this exercise. Repeat 10 times



4. Hamstring Stretch - 10 reps

Lie on your back. Keeping one leg straight, bend the other and grab the back of your thigh as shown in the picture. Then slowly straighten the leg to the point of tightness. Slowly pull your toes toward your face. Hold for 15 seconds and then relax. Repeat 10 times each leg.



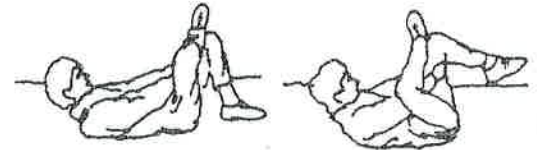
Please check when you have completed your exercises:

Patient: Back Stretch

Start Date:

5. Piriformis Stretch, Supine - 10 reps

Lie flat on your back with both knees bent and feet on floor. Cross involved ankle onto uninvolved knee. Slowly bring uninvolved knee to chest, feeling a stretch in involved hip. Hold 5 seconds. Repeat 10 times. Repeat on opposite side.



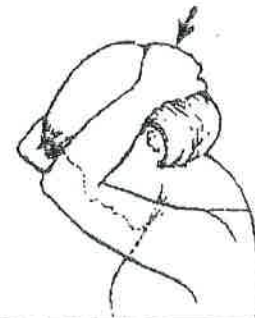
6. Sitting Stretch, Chair - 10 reps

Sit on edge of a chair, feet apart. Placing your hands on your knees, gently bend forward as far as possible. Slide hands down to ankle to increase the intensity of the stretch. Return to the starting position. Repeat 10 times.



7. Cervical Stretch Forward, Adv - 10 reps

Bend neck forward as if to touch your chin to your chest. Your tongue is in the resting position (front third of tongue against the roof of mouth with a slight pressure). Using your hand(s) pull the top of your head forward until you feel a stretch in the area between the back of your head and top of your neck. Hold for 5 seconds and repeat 10 times.



8. Sidebending, with Overpressure - 10 reps

Bend your head toward your right shoulder continuing to look straight ahead. Reach across the top of your head with your right hand and gently pull your head towards your shoulder. Hold for 5 seconds and return to the starting position. Repeat 10 times. Repeat toward the left.



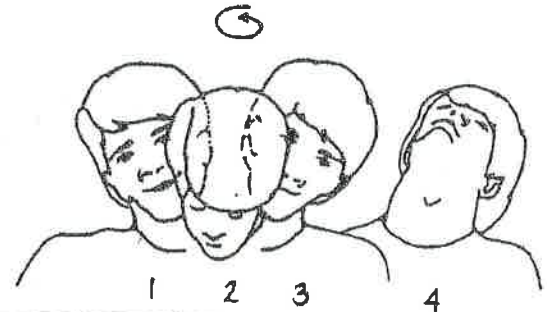
Please check when you have completed your exercises:

Patient: Back Stretch

Start Date:

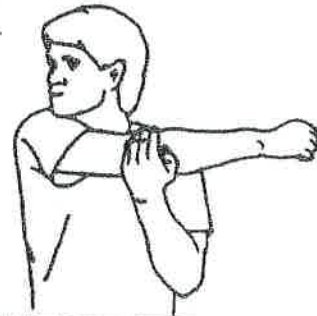
9. Head Circles - 10 reps

Slowly rotate your head in a clockwise direction. Be gentle and do not exaggerate the motions. After 10 circles, repeat in the counter-clockwise direction.



10. Posterior Cuff Stretch, AAROM - 10 reps

Bring your involved arm across your chest. Rotate your head toward your involved shoulder while pulling at the elbow with your other arm. Hold for 5 seconds. Relax and repeat 10 times.

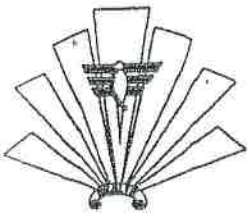


Please check when you have completed your exercises:

SUPPLEMENTAL- # 1

February 11, 2013

12:55pm

**CORNERSTONE PROFESSIONAL EDUCATION SEMINARS, INC.****POST MUA THERAPY**

The second most important part of the MUA procedure is the post MUA therapy. References state that chronic fibroadhesions will reform into dense fibrous meshes after remodeling has been attempted in only 24 hours if follow-up motion is not provided. Post MUA therapy focuses on maintaining the postural integration that has been achieved by the procedure and goes one step further in providing the necessary foundation for the rehabilitation to follow.

One further note. It is this author's opinion that a form of postural kinesthetic integration in the form of proprioception change has occurred using this procedure. As stated in class, I believe that it has something to do with maintaining certain positions during the procedure. I have found that if these positions are maintained for the first 3-5 days following the MUA procedure while performing the therapy, that the patients respond better and the outcome of the entire procedure has a longer lasting effect on the patient. It is for this reason that certain post MUA procedures are taught.

This therapy program is designed to have the utmost effect in the shortest period of time for the patient. The initial program is 7-10 days of straight therapy with the addition of adjustments on the day following the last day of the MUA procedure. This is followed by 2 weeks of regular conservative office care. (Back to the usual office therapy). Then the patient is placed into two weeks of "pre-rehab." Then 2-4 weeks of rehabilitation where strengthening is the predominant goal.

Post MUA Therapy Regiment:**1- Therapy For Same Day As MUA**

The patient is placed in the side lying position on the therapy table. Hydrocolator is placed in the area(s) of involvement for 5 minutes. (Used to superficially warm up the area).

After heating the area, the patient is placed back in the supine position and taken through the exact stretching procedures as were used during the MUA. (Note: the patient will respond best if only placed in the supine position or side lying just like during the MUA procedure).

After stretching, place patient on interferential and ice for 15 minutes then send home to rest for the day. (Note: this is not bed rest, although they may want to sleep some).

The patient is not to go to work on any of the days that the MUA procedure is being done, and it is recommended that they also take one more day after the MUA for the first day of post. MUA therapy.

2- Repeat Above For All Days Of Actual MUA

PNF exercises as shown in class may begin on the second day during the stretching phase if the patient is still stiff. This will also help with soreness if present.

3- Therapy For The Day(s) Following The Last MUA:

For the first 3-5 days maintain the supine or side lying posture during therapy.

The initial therapy is the same as same day therapy. Heat, and stretching, PNF exercises. Then an adjustment is given and for the first 3-5 days use the same adjustive procedures as were used during the MUA procedure. This would then be followed by interferential therapy and ice, and the patient would be sent home to rest.

(Note: I prefer to keep the patient out of work if possible for the initial 3-5 days. This gives ample time to get the therapy started and get the patient adapted to the regime of having therapy every day which we feel is essential for optimum results).

4- After 7-10 days of the same therapeutic regime as above, the patient is then placed back into the regular office care as he or she was in before the MUA. Some doctors prefer to continue the stretching part of the therapy program and then go to their usual adjustive procedures whatever that may be. This therapeutic time frame is for 2 weeks, and the frequency of visits is dropped to 3 times per week.

5- Following this two week period of time, the patient is placed into a "pre-rehab." program where they are introduced to strengthening exercises as part of the therapy. Here the patient should start using theraban in the office after the adjustment and before interferential and ice, and the patient should begin a home exercise program of stretching and mild strengthening. Adjustment frequency will usually be reduced to 2 times per week but you may see the patient for exercise therapy 3 times per week.

6- Following this two week period of time the patient should be placed into a 2-4 week rehabilitation program. The patient may be seen for adjustments once or twice per week but the primary goal during this program is to maintain the stretching and promote much greater strengthening than in previous "pre-rehab." phase. Frequency is every day.

Manipulation of Musculoskeletal System Under Anesthesia (General, Mild Sedation and Local)

DESCRIPTION

Manipulation under anesthesia (MUA) consists of passive movements and stretching of joints performed while the individual receives anesthesia (usually short acting anesthetics or moderate sedation).

Manipulation refers to a variety of manual adjustment techniques and is believed to ease pressure on nerves, break up fibrous scar tissue or restore normal musculoskeletal alignment to relieve pain and improve range of motion. Anesthesia or sedation is used to lessen pain, spasm and the conscious reflex muscle guarding; thereby reducing resistance and apprehension for the individual and enhance the therapeutic effects of the joint manipulation through a full range of motion. Manipulation procedures can be offered under general anesthesia, during mild sedation, or following the injection of anesthetic solutions (i.e. local anesthetic agent) into specific areas of the spine or joints. Typically, MUA is an alternative to conservative treatments that have lasted at least six to eight weeks without relieving pain or promoting a return to normal function.

Spinal manipulation under anesthesia has been used in the treatment of acute and chronic back and neck pain where there has been limited success of prior attempts to manipulate the spine. In MUA, a low velocity/high amplitude technique may be used in contrast to the high velocity/low amplitude technique that is used in the typical chiropractic/osteopathic adjustment.

MUA has also been used as a treatment for fibroarthrosis following total knee replacement, in refractory cases of adhesive capsulitis (frozen shoulder), in the setting of displaced fractures and complete joint dislocations, and for temporomandibular joint syndrome.

POLICY

- Manipulation under anesthesia is considered **medically necessary** if the medical appropriateness criteria are met. (See **Medical Appropriateness** below).
- Manipulation under anesthesia for other joints including the wrist, elbow, hand, finger, ankle, and pelvis, in the absence of fracture or complete dislocation, is considered **investigational**.
- Spinal manipulation under anesthesia, (e.g. general anesthesia, joint anesthesia, epidural anesthesia with corticosteroid injections) as a treatment for conditions including, but not limited to chronic spinal pain (e.g. cranial, cervical, thoracic, and lumbar) and chronic sacroiliac and pelvic pain, is considered **investigational**.
- Spinal manipulation and manipulation of other joints under anesthesia involving serial treatment sessions (greater than 1 treatment) is considered **investigational**.

See also:

- Intravenous Anesthetics for the Treatment of Chronic Pain
- Modified Condylotomy for Treatment of Temporomandibular Joint (TMJ) Disorders
- Orthognathic Surgery
- Temporomandibular Joint (TMJ) Arthroscopy

MEDICAL APPROPRIATENESS

- Manipulation under anesthesia is considered **medically appropriate** if **ANY ONE** of the following criteria are met:
 - ◊ Treatment of adhesive capsulitis that has failed at least 3 months of conservative interventions (e.g. physical therapy, patient directed exercise, NSAIDS, and/or steroid injections)

- Arthrofibrosis of the knee following total knee arthroplasty, knee surgery, or fracture
- Temporomandibular joint disorder
- Closed reduction of displaced fracture
- Complete joint dislocation

SUPPLEMENTAL- # 1

February 11, 2013

12:55pm

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the Medical Policy and a health plan, the express terms of the health plan will govern.

ADDITIONAL INFORMATION

As with any treatment of pain, controlled clinical trials are considered particularly important to isolate the contribution of the intervention and to assess the extent of the expected placebo effect. A search of the published medical literature did not identify any controlled clinical trials. Several case series were identified, which included individuals with cervical, thoracic and lumbar back pain, treated according to varying protocols.

SOURCES

BlueCross BlueShield Association. Medical Policy Reference Manual. (4:2010). *Manipulation under anesthesia for the treatment of chronic and pelvic pain*. (8.01.40). Retrieved December 13, 2010 from BlueWeb. (7 articles and/or guidelines reviewed)

Cremata, E., Collins, S., Clauson, W., Solinger, A., & Roberts, E. (2005) Manipulation under anesthesia: A report of four cases. *Journal of Manipulative and Physiological Therapeutics*, 28 (7), 526-533. (Level 4 Evidence - Independent)

ECRI Institute. Health Technology Information Service. Evidence Reports. (2003, February). *Manipulation under anesthesia for low-back pain*. Retrieved December 10, 2010 from ECRI Institute. (66 articles and/or guidelines reviewed)

Kawchuk, G., Haugen, R., Fritz, J. (2009). A true blind for subjects who receive spinal manipulation therapy. *Archives of Physical Medicine and Rehabilitation*, 90 (2), 366-368. (Level 4 Evidence - Independent)

Manske, R., Prohaska, D. (2008). Diagnosis and management of adhesive capsulitis. *Current Reviews of Musculoskeletal Medicine*, 1 (3-4), 180-189. (Level 5 Evidence - Independent.)

Mohammed, R., Syed, S., & Ahmed, N. (2009). Manipulation under anesthesia for stiffness following knee arthroplasty. *Annals of the Royal College of Surgeons of England*, 91 (3), 220-223. (Level 4 Evidence - Independent)

ORIGINAL EFFECTIVE DATE: 8/1/2002

MOST RECENT REVIEW DATE: 5/14/2011

ID_BT

Policies included in the Medical Policy Manual are not intended to certify coverage availability. They are medical determinations about a particular technology, service, drug, etc. While a policy or technology may be medically necessary, it could be excluded in a member's benefit plan. Please check with the appropriate claims department to determine if the service in question is a covered service under a particular benefit plan. Use of the Medical Policy Manual is not intended to replace independent medical judgment for treatment of individuals. The content on this Web site is not intended to be a substitute for professional medical advice in any way. Always seek the advice of your physician or other qualified health care provider if you have questions regarding a medical condition or treatment.

This document has been classified as public information.

Last Update: 05/01/2012

This is not a Contract

BlueCare

Professional Maximum Allowable Detail Report

Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator
20936		\$0.00	BU	21073		\$284.34		21181		\$1,019.49	
20937		\$166.22		21076		\$861.54		21182		\$4,082.01	
20938		\$180.62		21077		\$2,166.94		21183		\$4,082.01	
20950		\$107.26		21079		\$1,476.03		21184		\$4,082.01	
20955		\$2,483.85		21080		\$1,674.31		21188		\$1,341.77	
20956		\$2,410.91		21081		\$1,516.43		21193		\$1,003.69	
20957		\$2,365.65		21082		\$1,326.60		21194		\$1,137.98	
20962		\$2,406.77		21083		\$1,287.48		21195		\$1,047.46	
20969		\$2,752.62		21084		\$1,486.39		21196		\$1,123.10	
20970		\$2,667.47		21085		\$572.04		21198		\$931.34	
20972		\$2,425.13		21086		\$1,648.41		21199		\$918.81	
20973		\$2,598.53		21087		\$1,593.24		21206		\$845.56	
20974		\$112.74		21088		\$178.41	IC-AP	21208		\$714.35	
20975		\$170.92		21089		\$0.00	UL-OP	21209		\$498.15	
20979		\$40.86		21100		\$302.29		21210		\$687.74	
20982		\$3,672.06		21110		\$362.12		21215		\$710.52	
20985		\$118.95		21116		\$225.98		21230		\$730.49	
20999		\$0.00	UL-OP	21120		\$458.30		21235		\$590.33	
21010		\$623.14		21121		\$523.02		21240		\$1,003.86	
21011		\$272.60		21122		\$542.44		21242		\$1,038.63	
21012		\$294.03		21123		\$689.21		21243		\$1,245.06	
21013		\$424.80		21125		\$646.18		21244		\$829.38	
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21015		\$414.33		21137		\$587.91		21246		\$837.55	
21016		\$912.50		21138		\$770.54		21247		\$1,506.28	
21025		\$581.95		21139		\$851.01		21248		\$889.60	
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21044		\$706.75		21151		\$1,653.82		21268		\$1,310.31	
21045		\$958.51		21154		\$1,803.26		21270		\$706.91	
21046		\$811.39		21155		\$2,038.97		21275		\$760.26	
21047		\$1,005.51		21159		\$2,467.15		21280		\$424.73	
21048		\$835.62		21160		\$2,920.26		21282		\$317.27	
21049		\$957.97		21172		\$2,254.19		21295		\$152.17	
21050		\$768.33		21175		\$2,467.15		21296		\$311.92	
21060		\$722.82		21179		\$2,467.15		21299		\$0.00	UL-OP
21070		\$506.46		21180		\$2,467.15		21310		\$89.31	

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Last Update: 05/01/2012

This is not a Contract

BlueCare**Professional Maximum Allowable Detail Report**

Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator
22328		\$268.36		22843		\$800.72		23105		\$621.71	
22505		\$193.67		22844		\$968.11		23106		\$472.89	
22520		\$456.79		22845		\$883.54		23107		\$640.44	
22521		\$428.44		22846		\$746.73		23120		\$523.32	
22522		\$149.62		22847		\$822.45		23125		\$677.03	
22523		\$531.02		22848		\$392.34		23130		\$567.52	
22524		\$508.83		22849		\$1,139.27		23140		\$495.06	
22525		\$244.52		22850		\$647.15		23145		\$687.87	
22526		\$1,664.27		22851		\$435.72		23146		\$583.16	
22527		\$1,349.38		22852		\$627.10		23150		\$605.83	
22532		\$1,436.09		22855		\$922.15		23155		\$723.96	
22533		\$1,345.93		22856		\$1,391.75		23156		\$628.47	
22534		\$338.46		22857		\$1,206.44		23170		\$558.90	
22548		\$1,629.97		22861		\$1,714.72		23172		\$571.26	
22551		\$1,652.89		22862		\$1,460.09		23174		\$697.31	
22552		\$386.36		22864		\$1,566.80		23180		\$718.01	
22554		\$1,224.57		22865		\$1,422.04		23182		\$739.45	
22556		\$1,491.03		22899		\$0.00	UL-OP	23184		\$789.88	
22558		\$1,370.13		22900		\$346.64		23190		\$519.39	
22585		\$330.58		22901		\$580.48		23195		\$701.05	
22590		\$1,352.50		22902		\$364.41		23200		\$861.37	
22595		\$1,282.73		22903		\$384.28		23210		\$877.39	
22600		\$1,081.72		22904		\$909.72		23220		\$1,003.75	
22610		\$1,070.88		22905		\$1,179.62		23330		\$202.43	
22612		\$1,351.01		22999		\$0.00	UL-OP	23331		\$515.31	
22614		\$380.04		23000		\$406.27		23332		\$798.21	
22630		\$1,342.33		23020		\$642.10		23350		\$266.80	
22632		\$312.67		23030		\$287.03		23395		\$1,057.79	
22633		\$1,739.10		23031		\$243.67		23397		\$1,069.66	
22634		\$468.02		23036		\$733.26		23400		\$911.18	
22800		\$1,197.18		23040		\$691.89		23405		\$596.74	
22802		\$1,929.98		23044		\$569.67		23406		\$751.19	
22804		\$2,199.63		23065		\$150.18		23410		\$848.58	
22806		\$1,609.76		23066		\$343.50		23412		\$916.64	
22810		\$1,791.14		23071		\$364.26		23415		\$654.29	
22812		\$1,995.13		23073		\$604.06		23420		\$947.23	
22818		\$1,969.13		23075		\$226.59		23430		\$693.85	
22819		\$2,127.59		23076		\$508.39		23440		\$716.95	
22830		\$750.67		23077		\$1,002.07		23450		\$918.16	
22840		\$983.39		23078		\$1,227.62		23455		\$990.58	
22841		\$0.00	BU	23100		\$478.68		23460		\$1,031.68	
22842		\$1,096.16		23101		\$460.85		23462		\$1,034.19	

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BlueCare**Professional Maximum Allowable Detail Report**

Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator
23465		\$1,007.95		23929		\$0.00	UL-OP	24305		\$479.21	
23466		\$983.86		23930		\$264.00		24310		\$434.23	
23470		\$1,142.41		23931		\$203.51		24320		\$708.17	
23472		\$1,302.47		23935		\$561.34		24330		\$637.67	
23480		\$749.36		24000		\$412.50		24331		\$696.51	
23485		\$906.23		24006		\$610.09		24332		\$445.16	
23490		\$779.04		24065		\$213.18		24340		\$532.73	
23491		\$952.54		24066		\$423.37		24341		\$534.70	
23500		\$178.25		24071		\$353.43		24342		\$706.24	
23505		\$293.55		24073		\$607.40		24343		\$582.79	
23515		\$526.24		24075		\$352.07		24344		\$880.78	
23520		\$176.84		24076		\$431.04		24345		\$582.79	
23525		\$281.12		24077		\$841.76		24346		\$880.78	
23530		\$542.27		24079		\$1,131.63		24357		\$344.73	
23532		\$561.50		24100		\$354.48		24358		\$405.29	
23540		\$195.64		24101		\$443.14		24359		\$499.32	
23545		\$253.04		24102		\$559.11		24360		\$816.40	
23550		\$527.48		24105		\$286.04		24361		\$896.04	
23552		\$583.69		24110		\$564.68		24362		\$940.10	
23570		\$184.42		24115		\$652.97		24363		\$1,213.03	
23575		\$311.93		24116		\$802.10		24365		\$565.00	
23585		\$619.37		24120		\$454.82		24366		\$626.56	
23600		\$266.69		24125		\$502.53		24400		\$778.41	
23605		\$422.40		24126		\$544.36		24410		\$1,013.19	
23615		\$673.56		24130		\$449.87		24420		\$986.12	
23616		\$1,375.25		24134		\$814.50		24430		\$900.51	
23620		\$239.33		24136		\$530.87		24435		\$941.00	
23625		\$352.53		24138		\$537.21		24470		\$572.27	
23630		\$534.13		24140		\$802.03		24495		\$584.23	
23650		\$268.22		24145		\$589.14		24498		\$820.99	
23655		\$293.43		24147		\$591.59		24500		\$263.34	
23660		\$539.25		24149		\$905.98		24505		\$443.90	
23665		\$376.37		24150		\$957.09		24515		\$784.62	
23670		\$570.68		24152		\$651.08		24516		\$793.98	
23675		\$460.45		24155		\$744.43		24530		\$301.46	
23680		\$701.93		24160		\$513.99		24535		\$509.16	
23700		\$191.27		24164		\$436.31		24538		\$659.97	
23800		\$998.54		24200		\$206.40		24545		\$713.98	
23802		\$1,113.92		24201		\$403.52		24546		\$993.75	
23900		\$1,205.56		24220		\$299.31		24560		\$240.06	
23920		\$1,002.92		24300		\$318.04		24565		\$428.59	
23921		\$403.43		24301		\$665.32		24566		\$570.91	

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BlueCare

Professional Maximum Allowable Detail Report

Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator
24575		\$662.97		25071		\$370.31		25272		\$661.00	
24576		\$236.00		25073		\$461.24		25274		\$748.13	
24577		\$445.48		25075		\$322.59		25275		\$563.19	
24579		\$769.45		25076		\$495.37		25280		\$653.84	
24582		\$615.95		25077		\$803.50		25290		\$611.28	
24586		\$962.20		25078		\$987.30		25295		\$611.59	
24587		\$946.68		25085		\$485.84		25300		\$623.63	
24600		\$338.65		25100		\$344.74		25301		\$599.54	
24605		\$338.50		25101		\$395.98		25310		\$719.93	
24615		\$619.25		25105		\$519.61		25312		\$801.59	
24620		\$450.52		25107		\$535.09		25315		\$846.66	
24635		\$959.10		25109		\$402.45		25316		\$973.11	
24640		\$136.69		25110		\$357.92		25320		\$736.58	
24650		\$208.54		25111		\$300.46		25332		\$785.97	
24655		\$364.16		25112		\$368.21		25335		\$906.22	
24665		\$582.14		25115		\$767.01		25337		\$756.37	
24666		\$678.32		25116		\$684.29		25350		\$755.56	
24670		\$218.63		25118		\$379.27		25355		\$848.98	
24675		\$384.84		25119		\$527.19		25360		\$736.57	
24685		\$626.91		25120		\$607.51		25365		\$951.56	
24800		\$740.21		25125		\$693.21		25370		\$1,038.40	
24802		\$891.83		25126		\$681.07		25375		\$1,036.40	
24900		\$683.17		25130		\$415.50		25390		\$852.55	
24920		\$704.13		25135		\$507.13		25391		\$1,026.44	
24925		\$535.93		25136		\$416.10		25392		\$1,033.04	
24930		\$720.76		25145		\$630.04		25393		\$1,122.31	
24931		\$846.35		25150		\$591.32		25394		\$659.41	
24935		\$983.03		25151		\$660.50		25400		\$895.10	
24940		\$696.64		25170		\$892.42		25405		\$1,094.48	
24999		\$0.00	UL-OP	25210		\$459.42		25415		\$1,026.56	
25000		\$319.10		25215		\$642.09		25420		\$1,208.98	
25001		\$266.23		25230		\$424.77		25425		\$1,186.57	
25020		\$509.08		25240		\$473.59		25426		\$1,172.44	
25023		\$915.41		25246		\$293.56		25430		\$587.07	
25024		\$620.66		25248		\$428.19		25431		\$583.49	
25025		\$1,006.68		25250		\$494.04		25440		\$724.63	
25028		\$440.89		25251		\$709.24		25441		\$865.91	
25031		\$378.91		25259		\$314.48		25442		\$721.61	
25035		\$698.85		25260		\$709.81		25443		\$817.04	
25040		\$527.39		25263		\$704.42		25444		\$805.30	
25065		\$137.74		25265		\$819.86		25445		\$753.08	
25066		\$345.80		25270		\$605.57		25446		\$1,117.36	

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Last Update: 05/01/2012

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BlueCare

Professional Maximum Allowable Detail Report

2013 FEB 11 PM 1:09

Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator
25447		\$725.92		25690		\$416.67		26117		\$712.02	
25449		\$964.06		25695		\$588.56		26118		\$926.57	
25450		\$637.88		25800		\$703.47		26121		\$699.15	
25455		\$699.32		25805		\$798.26		26123		\$796.26	
25490		\$794.44		25810		\$752.22		26125		\$404.44	
25491		\$828.45		25820		\$564.56		26130		\$603.68	
25492		\$902.95		25825		\$674.95		26135		\$677.78	
25500		\$212.85		25830		\$813.28		26140		\$617.95	
25505		\$408.58		25900		\$719.51		26145		\$624.37	
25515		\$635.47		25905		\$767.76		26180		\$312.42	
25520		\$475.28		25907		\$662.59		26170		\$396.52	
25525		\$824.63		25909		\$749.80		26180		\$418.43	
25526		\$936.12		25915		\$1,273.00		26185		\$436.00	
25530		\$198.79		25920		\$610.53		26200		\$545.84	
25535		\$405.82		25922		\$547.75		26205		\$683.68	
25545		\$624.82		25924		\$605.96		26210		\$539.89	
25560		\$211.98		25927		\$708.70		26215		\$635.17	
25565		\$440.80		25929		\$495.15		26230		\$561.02	
25574		\$527.91		25931		\$667.71		26235		\$545.56	
25575		\$732.14		25999		\$0.00	UL-OP	26236		\$506.27	
25600		\$230.36		26010		\$178.52		26250		\$720.38	
25605		\$445.85		26011		\$259.58		26260		\$693.91	
25606		\$546.40		26020		\$486.96		26262		\$563.47	
25607		\$552.36		26025		\$503.37		26320		\$464.04	
25608		\$630.16		26030		\$565.54		26340		\$240.15	
25609		\$804.17		26034		\$593.59		26341		\$93.33	
25622		\$223.66		26035		\$770.36		26350		\$710.04	
25624		\$375.44		26037		\$611.18		26352		\$767.67	
25628		\$599.25		26040		\$421.17		26356		\$833.47	
25630		\$236.81		26045		\$550.78		26357		\$833.19	
25635		\$364.43		26055		\$300.25		26358		\$854.74	
25645		\$547.62		26060		\$276.19		26370		\$776.50	
25650		\$249.19		26070		\$407.52		26372		\$837.39	
25651		\$344.23		26075		\$435.25		26373		\$877.99	
25652		\$508.47		26080		\$466.64		26390		\$763.41	
25660		\$324.06		26100		\$342.12		26392		\$938.38	
25670		\$574.52		26105		\$433.47		26410		\$552.85	
25671		\$419.55		26110		\$416.34		26412		\$651.07	
25675		\$367.90		26111		\$359.08		26415		\$717.16	
25676		\$582.87		26113		\$472.59		26416		\$811.28	
25680		\$397.74		26115		\$336.48		26418		\$532.35	
25685		\$674.77		26116		\$536.14		26420		\$682.26	

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27033		\$894.80		27125		\$1,014.18		27244		\$1,048.31	
27035		\$1,098.14		27130		\$1,347.29		27245		\$1,272.97	
27036		\$903.93		27132		\$1,541.85		27246		\$379.53	
27040		\$250.92		27134		\$1,854.46		27248		\$725.17	
27041		\$588.59		27137		\$1,413.15		27250		\$430.13	
27043		\$409.75		27138		\$1,472.87		27252		\$619.54	
27045		\$651.53		27140		\$832.17		27253		\$857.18	
27047		\$516.91		27146		\$1,114.39		27254		\$1,138.19	
27048		\$455.06		27147		\$1,331.32		27256		\$270.65	
27049		\$908.69		27151		\$1,457.54		27257		\$343.39	
27050		\$361.42		27156		\$1,566.36		27258		\$1,015.41	
27052		\$481.01		27158		\$1,282.76		27259		\$1,373.62	
27054		\$646.26		27161		\$1,088.02		27265		\$355.74	
27057		\$814.94		27165		\$1,168.63		27266		\$492.15	
27059		\$1,601.91		27170		\$1,072.88		27267		\$323.88	
27060		\$417.96		27175		\$497.83		27268		\$399.21	
27062		\$403.26		27176		\$781.88		27269		\$954.84	
27065		\$464.09		27177		\$951.02		27275		\$182.03	
27066		\$739.37		27178		\$769.15		27280		\$921.89	
27067		\$952.76		27179		\$821.20		27282		\$792.78	
27070		\$853.65		27181		\$915.92		27284		\$1,111.54	
27071		\$916.74		27185		\$604.99		27286		\$1,119.24	
27075		\$1,161.19		27187		\$950.10		27290		\$1,500.10	
27076		\$1,444.72		27193		\$399.55		27295		\$1,179.60	
27077		\$1,490.42		27194		\$619.12		27299		\$0.00	UL-OP
27078		\$930.18		27200		\$450.99		27301		\$631.56	
27080		\$464.61		27202		\$765.22		27303		\$693.32	
27086		\$196.14		27215		\$714.38		27305		\$467.26	
27087		\$555.32		27216		\$967.93		27306		\$361.38	
27090		\$758.11		27217		\$955.13		27307		\$430.06	
27091		\$1,415.07		27218		\$1,269.95		27310		\$663.26	
27093		\$332.90		27220		\$447.02		27323		\$227.23	
27095		\$298.17		27222		\$773.88		27324		\$362.81	
27096		\$407.76		27226		\$1,008.73		27325		\$407.02	
27097		\$624.45		27227		\$1,465.10		27326		\$384.31	
27098		\$630.10		27228		\$1,661.00		27327		\$383.35	
27100		\$769.61		27230		\$412.10		27328		\$406.66	
27105		\$780.40		27232		\$694.50		27329		\$963.21	
27110		\$853.47		27235		\$832.77		27330		\$378.61	
27111		\$814.81		27236		\$1,034.77		27331		\$447.98	
27120		\$1,174.77		27238		\$394.40		27332		\$593.86	
27122		\$1,036.53		27240		\$793.94		27333		\$626.96	

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Professional Maximum Allowable Detail Report

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27334		\$633.66		27427		\$659.31		27508		\$426.36	
27335		\$714.11		27428		\$936.45		27509		\$536.12	
27337		\$364.99		27429		\$997.16		27510		\$577.47	
27339		\$658.11		27430		\$671.68		27511		\$946.27	
27340		\$326.49		27435		\$642.10		27513		\$1,174.79	
27345		\$439.69		27437		\$627.23		27514		\$1,135.94	
27347		\$308.69		27438		\$786.90		27516		\$426.14	
27350		\$589.41		27440		\$739.32		27517		\$633.10	
27355		\$587.01		27441		\$745.36		27519		\$983.65	
27356		\$684.77		27442		\$836.53		27520		\$263.72	
27357		\$744.37		27443		\$853.39		27524		\$672.64	
27358		\$283.09		27445		\$1,243.52		27530		\$314.00	
27360		\$882.66		27446		\$1,103.82		27532		\$506.06	
27364		\$1,377.05		27447		\$1,417.18		27535		\$808.95	
27365		\$1,067.88		27448		\$800.25		27536		\$973.21	
27370		\$324.28		27450		\$974.64		27538		\$392.42	
27372		\$419.34		27454		\$1,166.03		27540		\$831.34	
27380		\$529.14		27455		\$875.95		27550		\$415.65	
27381		\$721.76		27457		\$893.55		27552		\$510.93	
27385		\$566.12		27465		\$955.21		27556		\$983.59	
27386		\$750.14		27466		\$1,083.31		27557		\$1,121.11	
27390		\$411.15		27468		\$1,266.86		27558		\$1,162.64	
27391		\$520.33		27470		\$1,117.22		27560		\$295.72	
27392		\$661.84		27472		\$1,227.04		27562		\$391.43	
27393		\$479.24		27475		\$612.19		27566		\$792.10	
27394		\$612.95		27477		\$717.65		27570		\$152.74	
27395		\$842.87		27479		\$833.63		27580		\$1,249.31	
27396		\$593.87		27485		\$614.33		27590		\$830.52	
27397		\$772.93		27486		\$1,285.16		27591		\$905.06	
27400		\$664.52		27487		\$1,649.28		27592		\$734.71	
27403		\$594.86		27488		\$1,062.52		27594		\$506.42	
27405		\$629.97		27495		\$1,096.22		27596		\$755.76	
27407		\$702.97		27496		\$442.61		27598		\$747.83	
27409		\$882.97		27497		\$492.36		27599		\$0.00	UL-OP
27412		\$1,401.88		27498		\$575.89		27600		\$441.79	
27415		\$1,160.36		27499		\$620.95		27601		\$416.17	
27416		\$747.28		27500		\$489.14		27602		\$512.06	
27418		\$765.51		27501		\$513.94		27603		\$573.48	
27420		\$690.47		27502		\$723.11		27604		\$427.69	
27422		\$688.19		27503		\$722.78		27605		\$352.09	
27424		\$689.13		27506		\$1,123.08		27606		\$455.14	
27425		\$410.39		27507		\$950.62		27607		\$661.59	

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Professional Maximum Allowable Detail Report

Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator	Code	Modifier	Maximum Allowable	Indicator
27610		\$617.27		27696		\$590.52		27814		\$738.73	
27612		\$529.16		27698		\$652.95		27816		\$280.04	
27613		\$219.31		27700		\$616.51		27818		\$446.16	
27614		\$500.88		27702		\$1,037.86		27822		\$975.14	
27615		\$931.10		27703		\$1,050.58		27823		\$1,111.65	
27616		\$1,123.55		27704		\$505.93		27824		\$290.44	
27618		\$469.01		27705		\$748.95		27825		\$485.73	
27619		\$668.72		27707		\$392.86		27826		\$916.38	
27620		\$455.10		27709		\$732.58		27827		\$1,189.73	
27625		\$610.27		27712		\$947.18		27828		\$1,298.15	
27626		\$658.81		27715		\$995.58		27829		\$644.98	
27630		\$476.88		27720		\$867.18		27830		\$286.24	
27632		\$360.98		27722		\$836.43		27831		\$326.52	
27634		\$590.36		27724		\$1,053.09		27832		\$482.61	
27635		\$612.95		27725		\$1,041.28		27840		\$320.16	
27637		\$726.30		27726		\$711.81		27842		\$370.14	
27638		\$771.04		27727		\$909.73		27846		\$680.92	
27640		\$922.92		27730		\$655.91		27848		\$897.78	
27641		\$769.75		27732		\$528.54		27860		\$184.48	
27645		\$1,044.87		27734		\$598.28		27870		\$954.58	
27646		\$941.41		27740		\$793.68		27871		\$662.34	
27647		\$807.70		27742		\$850.93		27880		\$799.39	
27648		\$256.37		27745		\$720.45		27881		\$867.87	
27650		\$660.79		27750		\$283.69		27882		\$710.24	
27652		\$705.82		27752		\$458.06		27884		\$586.38	
27654		\$705.46		27756		\$562.99		27886		\$677.20	
27656		\$495.08		27758		\$819.18		27888		\$696.28	
27658		\$565.08		27759		\$946.35		27889		\$704.39	
27659		\$713.40		27760		\$263.68		27892		\$500.76	
27664		\$490.46		27762		\$409.09		27893		\$507.28	
27665		\$570.22		27766		\$579.36		27894		\$655.40	
27675		\$507.15		27767		\$197.10		27899		\$0.00	UL-OP
27676		\$594.59		27768		\$306.59		28001		\$217.13	
27680		\$433.21		27769		\$532.10		28002		\$342.09	
27681		\$490.47		27780		\$243.12		28003		\$586.63	
27685		\$524.54		27781		\$349.45		28005		\$591.86	
27686		\$738.59		27784		\$510.53		28008		\$354.87	
27687		\$470.69		27786		\$256.05		28010		\$288.69	
27690		\$598.42		27788		\$351.69		28011		\$369.91	
27691		\$693.80		27792		\$538.69		28020		\$427.00	
27692		\$113.88		27808		\$281.69		28022		\$380.86	
27695		\$513.41		27810		\$419.08		28024		\$358.60	

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MANIPULATION UNDER ANESTHESIA

Policy Number: 2012T0515F
Effective Date: May 1, 2012

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INSTRUCTIONS FOR USE

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COVERAGE RATIONALE

Manipulation under anesthesia (MUA) is proven for:

- Elbow joint for arthrofibrosis following elbow surgery or fracture
- Knee joint for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture
- Pelvis for acute traumatic fracture or dislocation
- Shoulder joint for adhesive capsulitis (e.g. frozen shoulder)

Manipulation under anesthesia is unproven for:

- Ankle
- Finger*
- Hip joint or adhesive capsulitis of the hip
- Knee joint for any condition other than for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture
- Pelvis for diastasis or subluxation

- Shoulder for any condition other than adhesive capsulitis (frozen shoulder)
- Spine
- Temporomandibular joint (TMJ)
- Toe
- Wrist

Published studies which are available are of relatively small sample size, short-term outcomes and lack of randomization or a control group.

* This policy does not apply to manipulation of the finger on the day following the injection of collagenase clostridium histolyticum (Xiaflex®) to treat Dupuytren's contracture.

Manipulation under anesthesia is unproven for serial manipulations for any body part or multiple body joints for the management of acute or chronic pain conditions. There is a lack of peer-reviewed published evidence supporting the need for multiple, repeat sessions of MUA for multiple body joints.

BACKGROUND

Manipulation under anesthesia (MUA) is a non-invasive procedure which combines manual manipulation of a joint or the spine with an anesthetic. In patients who are unable to tolerate manual procedures due to pain, spasm, muscle contractures, or guarding may benefit from the use of an anesthetic agent prior to manipulation. Anesthetics may include intravenous general anesthesia or mild sedation, injection of an anesthetic to the affected area, oral medication such as muscle relaxants, inhaled anesthetics, or any other type of anesthetic medication therapy. Because the patient's protective reflex mechanism is absent under anesthesia, manipulation using a combination of specific short lever manipulations, passive stretches, and specific articular and postural kinesthetic maneuvers in order to break up fibrous adhesions and scar tissue around the joint, spine and surrounding tissue is made less difficult. Manipulation procedures can be performed under either: general anesthesia, mild sedation, or local injection of an anesthetic agent to the affected area (Reid, 2002).

Manipulation under anesthesia (MUA) may be accompanied by fluoroscopically-guided intra-articular injections with corticosteroid agents to reduce inflammation or manipulation under joint anesthesia/analgesia (MUJA). Manipulation under epidural anesthesia (MUEA) employs an epidural, segmental anesthetic, often with simultaneous epidural steroid injections, followed by spinal manipulation therapy. Other therapies may combine manipulation with cortisone injections into paraspinal tissues or joint spaces.

Spinal manipulation under anesthesia (SMUA) consists of spinal manipulation and stretching procedures performed on the patient after an anesthetic is administered (e.g., mild sedation, general anesthesia) and may be recommended when standard chiropractic care and other conservative measures have been unsuccessful. This is typically performed by chiropractors, osteopathic physicians, and orthopedic physicians along with an anesthesiologist. Theoretically, SMUA is thought to stretch the joint capsules to break up adhesions within the spinal column to allow for greater mobility and reduced back pain; however, this has not been proven in the peer-reviewed literature.

Note: Unless otherwise specified, this policy does not address closed reduction of a fracture or joint dislocation.

CLINICAL EVIDENCE

Manipulation under anesthesia may be performed for a variety of musculoskeletal conditions which may include the ankle, elbow, finger/toe, hip, knee, shoulder, pelvis and pelvic ring fracture, dislocation, diastasis or subluxation, and the spine.

Ankle

No evidence was identified within the evidence-based peer-reviewed literature concerning ankle manipulation under anesthesia for the treatment of any condition.

Elbow

There is little data within the evidence-based, peer reviewed literature concerning the safety and effectiveness of using manipulation under anesthesia of the elbow. Although some studies suggest that it may be useful in the early-post operative recovery of patients with joint contractures, there is a lack of substantial evidence that validates this use.

Araghi and colleagues (2010) have used a technique of elbow examination (manipulation) under anesthesia in select patients. The study comprised 51 consecutive patients who underwent an examination under anesthesia.

Forty-four patients with a minimum of 12 months follow-up revealed a mean pre-examination arc of 33 degrees, which improved to 73 degrees at the final assessment. Three patients had no appreciable change (less than 10 degrees) in the total arc, and 1 patient lost motion. Four patients underwent a second examination under anesthesia at a mean of 119 days after the first examination. The average pre-examination arc of 40 degrees increased to 78 degrees at the final assessment (mean improvement of 38 degrees). The only complication was worsening of ulnar paresthesias in 3 patients; with 2 resolving spontaneously, and 1 requiring anterior ulnar nerve transposition. The authors concluded that because this was not a controlled series, additional studies should be conducted to better identify those not likely to benefit from this procedure. In addition, this study is limited by its small sample size and lack of a control group.

A retrospective review by Tan et al. (2006) looked at 52 patients who underwent open surgical treatment for post-traumatic elbow contracture at an average of 14 months from the time of injury. Indication for operative release was functional loss of elbow arc of motion that failed non-operative therapy and a splinting program. Follow-up was 18.7 months. Of the 52 patients, 14 required closed manipulation under anesthesia, in the early postoperative period. Five patients required a second contracture release at an average of 12 months after the index release. Four patients failed because of painful motion and elbow instability. The authors concluded that recurrence of post-traumatic stiffness in the postoperative period is common but is responsive to manipulation under anesthesia and repeat releases. The relatively small number of patients and lack of randomization and a control group are weaknesses of this study.

Antuna et al. (2002) reported in a study for ulnohumeral arthroplasty for primary degenerative arthritis of the elbow that 2 patients underwent elbow manipulation under anesthesia to improve the range of motion after the ulnohumeral arthroplasty. The indication for this procedure was loss of preoperative motion or of motion attained at surgery. Both patients underwent manipulation twice, and ulnar nerve symptoms developed after the second manipulation. The arc of motion increased 40° in one patient and 45° in the other. However, because of the ulnar symptoms they no longer recommend manipulation of the elbow in the early postoperative period if the nerve has not been decompressed or translocated. They felt that patients with postoperative stiffness after ulnohumeral arthroplasty might be better treated by progressive stretching with static splints.

Chao et al. (2002) reported in a study on surgical approaches for nonneurogenic elbow heterotopic ossification with ulnar neuropathy that forceful and repetitive manipulation may add further damage to an already stiffened elbow and should be avoided after immobilization or surgery.

Gaur (2003) reported on eight children (ten elbows) who were found to have severe heterotopic ossification of the elbow, leading to an inability to reach the mouth for feeding and the head and the perineum for self-care. Excision of the heterotopic ossification was undertaken if the patient had this limitation of function and if movement was restricted to a total arc of motion of $<50^\circ$. Four of the patients underwent a manipulation under anesthesia in the post-operative period. The nine elbows available for follow-up had an improved arc of motion (an average increase of 57°). This study is limited by small numbers and lack of any control group or randomization.

Finger

There is little data within the evidence-based, peer reviewed literature concerning the safety and effectiveness of using manipulation under anesthesia of the finger.

A case report of 3 patients by Guly and Azam (1982) reviews the use of manipulation for a locked finger. All 3 patients were treated with manipulation under anesthesia using a local anesthetic injected into the finger joint. Two patients had a locked middle finger and 1 patient had a locked index finger. In each case, the patient was successfully treated with gentle manipulation. This study is limited by small sample size and lack of randomization.

Hip

No studies that provide substantial evidence regarding the use of manipulation under anesthesia of the hip joint were identified.

Knee

The use of knee joint manipulation following total knee arthroplasty appears to be effective as a means of improving flexion of the joint. It also appears that this procedure may lead to a decrease in pain scores as reported within the literature.

Fitzsimmons et al. (2010) conducted a systematic review to compare manipulation under anesthesia (MUA) with arthroscopy and open arthrolysis for knee stiffness following total knee arthroplasty. The review evaluated 14,421 studies of which 23 were deemed relevant. MUA alone resulted in a mean gain in knee motion of 30 to 47 degrees. Range of motion in the arthroscopy group increased between 18.5 to 60 degrees. The open arthrolysis group had less gain in range of motion with gains between 19 and 31 degrees. The authors concluded that both MUA and arthroscopy provide similar gains in range of motion for patients with knee stiffness following total knee arthroplasty. Open arthrolysis had less favorable results.

Pariente et al. (2006) conducted a retrospective review on 333 patients who were unable to achieve adequate range of motion after total knee arthroplasty. The study was conducted to compare the efficacy of a modified manipulation technique, which uses epidural anesthesia continued for postoperative analgesia, hospital stay of one to three days, continuous passive motion (CPM) for two to three days, and daily physical therapy (PT) to standard manipulation under anesthesia. Manipulation using a standard technique was performed on 273 patients (334 knees) and manipulation using a modified technique was performed on 60 patients (65 knees). Average follow-up time was 18.4 months. With the modified technique, ROM improved from 71 degrees to 102 degrees, and knee society pain, function, and total clinical scores improved as well. Successful results were observed in 48 (74%) knees with 4 additional knees having a successful result after a subsequent manipulation. The authors concluded that manipulation under epidural anesthesia represents a viable option for treatment of persistent stiffness after total knee arthroplasty.

Keating et al. (2007) studied 90 patients (113 knees) who underwent manipulation for postoperative flexion of $<$ or ≥ 90 degrees at a mean of ten weeks after surgery. Flexion was measured with a goniometer prior to total knee arthroplasty, at the conclusion of the operative procedure, before manipulation, immediately after manipulation, at six months, and at one, three, and five years postoperatively. Of the 90 patients, 81 (90%) achieved improvement of ultimate knee flexion following manipulation. The average flexion was 102 degrees prior to total knee

arthroplasty, 111 degrees following skin closure, and 70 degrees before manipulation. There was no significant difference in the mean improvement in flexion when patients who had manipulation within twelve weeks postoperatively were compared with those who had manipulation more than twelve weeks postoperatively. The authors concluded that manipulation generally increases ultimate flexion following total knee arthroplasty and patients with severe preoperative pain are more likely to require manipulation.

Namba and Inacio (2007) reviewed 195 patients who had undergone manipulation under anesthesia; 102 within 90 days of total knee arthroplasty and 93 more than 90 days after total knee arthroplasty. Average pain (10-point scale), satisfaction (10-point scale), flexion (degrees), and extension (degrees) were recorded before and after MUA. Flexion was significantly improved after MUA for both groups: early MUA from 68.4 degrees (+/-17.2 degrees) to 101.4 degrees (+/-16.15 degrees); and late MUA from 81.0 degrees (+/-13.3 degrees) to 98.0 degrees (+/-18.0 degrees). Pain decreased significantly with early MUA from 4.92 (+/-2.25) to 3.34 (+/-2.67) and with late MUA from 4.51 (+/-2.62) to 3.44 (+/-2.78). Extension improved only in the early MUA group from 7.15 (+/-10.1) to 2.50 (+/-4.98). Satisfaction scores were not improved. The authors concluded that both early and late manipulation can improve TKA pain and flexion.

Multiple Joints

Evidence supporting the need for multiple, repeat sessions of MUA for these conditions was not found in the published medical literature.

Pelvis

There is little data within the evidence-based literature to assess the safety and efficacy of pelvic ring manipulation under anesthesia; however, the use of manipulation under anesthesia of the pelvis and/or pelvic ring as a result of fracture(s) or dislocation is an integral part of the restoration of the pelvic ring whether used as part of a closed or open-reduction surgical technique (Hayes, 2008).

No literature was found to support manipulation under anesthesia of the pelvis for diastasis or subluxation.

Shoulder

The use of shoulder manipulation under anesthesia to reduce pain and improve range of motion appears to be effective in patients with adhesive capsulitis (frozen shoulder) when conservative non-surgical treatment has failed.

A blinded, randomized trial with a 1 year follow-up, by Kivimaki et al. (2007) evaluated 125 patients with a frozen shoulder to determine the effect of manipulation under anesthesia. Patients were randomly assigned to either a manipulation group (65 patients) or a control group (60 patients). Both the intervention group and the control group were instructed in specific therapeutic exercises by physiotherapists. Clinical data was gathered at baseline and at 6 weeks and 3, 6, and 12 months after randomization. The 2 groups did not differ at any time of the follow-up in terms of shoulder pain or working ability. Small differences in the range of movement were detected in favor of the manipulation group. Perceived shoulder pain decreased during follow-up equally in the 2 groups, and at 1 year after randomization, only slight pain remained. The authors concluded that manipulation under anesthesia does not add effectiveness to an exercise program carried out by the patient after instruction.

Ng et al. (2009) conducted a prospective trial of 50 patients to examine the efficacy of manipulation under anaesthesia (MUA) followed by early physiotherapy in treating frozen shoulder syndrome. Disabilities of the Arm, Shoulder and Hand (DASH) score and visual analogue score (VAS) for pain and range of movement were measured preoperatively and at 6 weeks post-procedure. The mean DASH score decreased from 48.07 to 15.84 and the mean VAS reduced from 6.07 to 1.88. Flexion improved from 104.18 to 157.56; abduction from 70.48 to 150.00; and external rotation from 13.88 to 45.62. The authors concluded that MUA combined

with early physiotherapy alleviates pain and facilitates recovery of function in patients with frozen shoulder syndrome.

In a prospective trial conducted between 2001 and 2003 by Loew et al. (2005), 30 patients with primary frozen shoulder manipulated under general anesthesia were evaluated for post manipulative intra-articular lesions. Patients with secondary stiffness caused by rotator cuff tears and glenohumeral arthritis were excluded. Arthroscopy was used after manipulation to document any intra-articular lesions. All patients noted an improvement in range of motion. Flexion improved on average from 70 degrees (+/- 33 degrees) to 180 degrees (+/- 15 degrees), abduction from 50 degrees (+/- 20 degrees) to 170 degrees (+/- 25 degrees), and external rotation from -5 degrees (+/- 10 degrees) to +40 degrees (+/- 20 degrees). Localized synovitis was detected in 22 of the patients in the area of the rotator interval, whereas disseminated synovitis was observed in 8 patients. After manipulation, the capsule was seen to be ruptured superiorly in 11 patients, the anterior capsule was ruptured up to the infraglenoid pole in 24 patients, and 16 patients each had a capsular lesion located posteriorly. In 18 patients no additional joint damage was found and in 4 patients, iatrogenic superior labrum anterior-posterior lesions were observed. The authors concluded that even though manipulation under anesthesia is effective in terms of joint mobilization, the method can cause iatrogenic intra-articular damage.

Flannery et al. (2007) evaluated 180 consecutive patients to determine what influence timing of manipulation under anesthesia (MUA) had on long-term outcomes for adhesive capsulitis of the shoulder. Of the 180 patients, 145 were available for follow-up after a mean period of 62 months (range of 12 to 125). All patients underwent MUA with intra-articular steroid injection. Improvement was noted in range of motion and function utilizing the Oxford Shoulder Score (OSS) and Visual Analogue Score (VAS) following manipulation. Eighty-three percent of the patients had MUA performed less than 9 months from onset of symptoms (early MUA). The remainder had MUA performed 9 to 40 months (late MUA) from onset of symptoms. The authors found that both groups had better mobility and Oxford Shoulder Score as well as less pain; however the early intervention group had the most improvement.

In a study by Farrell et al. (2005), manipulation under anesthesia was performed in 25 patients (26 shoulders) for whom non-operative treatment for idiopathic frozen shoulder had failed. All of the patients had physical therapy for a mean of 6.2 months. Long-term follow-up was obtained in 18 patients (19 shoulders) by questionnaire and averaged 15 years (range, 8.1 to 20.6 years). There were significant improvements in forward elevation from a mean of 104 degrees before manipulation to 168 degrees and in external rotation from 23 degrees to 67 degrees. There were 16 shoulders with no pain or slight pain and 3 with occasional moderate or severe pain. Of the 19 shoulders, 18 required no further surgery. The mean Simple Shoulder Test score was 9.5 out of 12 and the mean American Shoulder and Elbow Surgeons score was 80 out of 100. The authors conclude that treatment of idiopathic frozen shoulder by manipulation under anesthesia leads to sustained improvement in shoulder motion and function at a mean of 15 years after the procedure.

Spine

There are several studies in evidence based peer-reviewed literature which recommend that additional studies are needed to support the safety and effectiveness of spinal manipulation under anesthesia.

In a prospective study of 68 chronic low-back pain patients, Kohlbeck et al. (2005) compared changes in pain and disability for chronic low-back pain patients receiving treatment with medication-assisted manipulation (MAM) to patients receiving spinal manipulation only. All patients received an initial 4- to 6-week trial of spinal manipulation therapy (SMT), after which 42 patients received supplemental intervention with MAM and the remaining 26 patients continued with SMT. Low back pain and disability measures favored the MAM group over the SMT-only group at 3 months. The authors concluded that medication-assisted manipulation appears to offer some patients increased improvement in low back pain and disability; however the study is limited

by lack of randomization, small sample size and significant baseline differences between groups for the primary outcome variable (pain/disability scale).

In a prospective controlled study by Palmieri and Smoyak (2002), 87 patients who received either spinal manipulation under anesthesia (SMUA) or traditional chiropractic treatment for low back pain were evaluated. The participants were assigned to one of two groups: 38 to an intervention group who received MUA and 49 patients to a nonintervention group who received traditional chiropractic treatment. Patients were followed for 4 weeks. Self-reported outcomes, including back pain severity and functional status, were used to evaluate changes. The MUA group had an average decrease of 50% in the Numeric Pain Scale scores while the nonintervention group had a 26% decrease. The MUA group had an average decrease of 51% in the Roland-Morris Questionnaire scores while the nonintervention group had a 38% decrease. The authors concluded that while there was greater improvement in the intervention group, additional studies are needed to evaluate the safety and effectiveness of MUA.

This study is flawed due to the methods used to select subjects, lack of assessor blinding, failure to isolate the effects of the active intervention, and interpretation of outcomes. Subjects were selected largely based upon 2 criteria: meeting NAMUAP eligibility requirements and having insurance coverage for MUA. This led to significant baseline heterogeneities between intervention and control groups. Sample size (N=87; MUA group = 38; SMT group = 49) did not reach anticipated number of participants. The attempt to measure the difference in treatment effect between MUA and SMT was confounded by the addition of a specific exercise protocol for the MUA group vs. an undefined "home exercise" program for the SMT group. Follow-up period was limited. Problems with obtaining timely follow-up data were reported. The use of a percentile difference in outcome scores between groups does not take into account if each outcome of interest exhibited a clinically meaningful difference between each group. In fact, there were no statistical or clinically meaningful differences between groups. There was a difference of 1.52 points on the NRS at initial follow-up and 1.32 points difference at final follow-up (the minimal clinically important change has been widely reported as 2 points). The difference at initial follow-up for the RMDQ was 2.2 points and at final follow-up was 1 point (as noted in the study, a 4 point difference is necessary for it to be clinically meaningful).

Cremata et al. (2005) reported the results of manipulation under anesthesia (MUA) for 4 patients with chronic spinal, sacroiliac, and/or pelvic and low back pain. Patients with chronic pain who had not adequately responded to conservative medical and/or a reasonable trial (4 months minimum) of chiropractic adjustments, and had no contraindications to anesthesia or adjustments, were selected. The 4 patients went through 3 consecutive days of MUA followed by an 8-week protocol of the same procedures plus physiotherapy in-office without anesthesia. Data included pre- and post-MUA passive ranges of motion, changes in the visual analog scale, neurologic and orthopedic examination findings. The patients had follow-up varying from 9 to 18 months and showed improvement in passive ranges of motion, decreases in the visual analog scale rating, and diminishment of subsequent visit frequency. The authors concluded that manipulation under anesthesia was an effective approach to restoring articular and myofascial movements in patients who did not adequately respond to either medical in-office conservative chiropractic adjustments and/or adjunctive techniques. Weaknesses of this study include small sample size and lack of randomization. Additional studies are needed to evaluate the safety and effectiveness of spinal MUA.

A descriptive case series reported on the outcomes of 177 subjects, who met a set of inclusion criteria, which included prior failed response to conventional manipulation (2-6 weeks trial) (West, 1999). All subjects underwent three serial MUAs. Post-MUA results included increased range of motion and clinically meaningful pain reduction. Both these outcomes showed continued improvement at 6-months follow-up. Unfortunately, the study design was incompatible with the objective of establishing a causal relationship i.e., the efficacy of MUA for a selected population. Additionally, an attempt to measure the strength of association of MUA with the outcomes was confounded by the inclusion of a broad range of other interventions rendered within the

framework of this study. Interventions reportedly included: passive modalities, different types of exercise, as well as traditional spinal manipulative therapy.

Temporomandibular Joint (TMJ)

Available evidence for manipulation under anesthesia for temporomandibular joint syndrome is limited to small, uncontrolled studies with limited follow-up.

Foster et al. (2000) studied 55 patients receiving manipulation under general anesthesia of the temporomandibular joint to determine the success rate of MUA effectiveness in an effort to reduce the number of patients being referred for invasive surgery. Of the 55 patients participating in this study, 15 improved, 15 did not, 6 showed partial improvement and 19 were not treated. The median pre-treatment opening was 20mm (range 13-27). Among those who improved after manipulation, the median opening after treatment was 38mm (range 35-56). The authors concluded that MUA may help some patients; however, some of those who improved experienced a return of TMJ clicking but not of joint or muscle tenderness.

Toe

No evidence was identified within the evidence-based peer-reviewed literature concerning manipulation under anesthesia of the toe.

Wrist

Available evidence for manipulation under anesthesia for wrist is limited to small, uncontrolled studies with limited follow-up or case studies.

Hanson et al. (1988) reported on 10 patients having thickening and contracture of the wrist joint capsule. Four of the 10 patients required manipulation under anesthesia which resulted in some improvement in range of motion. The authors note that while manipulation under anesthesia may be promising, careful technique and judicious patient selection are of paramount importance. Small sample size, lack of randomization, and no indication of follow-up are limitations of this study.

Professional Societies

The **International Chiropractors Association (ICA)**, in its 2000 publication *Recommended Clinical Protocols And Guidelines For The Practice Of Chiropractic*, ICA states that within the armamentarium of chiropractic techniques, efficient methods exist that address the pain profiles of even the most sensitive patient. Furthermore, the chiropractic adjustment relies on the body's own inherent constructive survival mechanisms to innately accomplish adjusted correction. In light of the above considerations, the International Chiropractors Association holds that anesthesia is inappropriate and unnecessary to the deliverance of a chiropractic adjustment.

The **International MUA Academy of Physicians** lists the following general indications for manipulation under anesthesia (IMUAA, 2006):

- Fibro adhesion buildup
- Chronic disc problems
- Herniated disc without fragmentation
- Chronic myofascitis
- Intractable pain from neuromusculoskeletal conditions
- Torticollis
- Chronic re-injury
- Failed back surgery

According to the **American College of Occupational and Environmental Medicine (ACOEM)** practice guidelines regarding physical methods of treatment for low back disorders (Hegmann, 2007;update: Hegmann, et al., 2008), due to insufficient evidence manipulation under anesthesia

(MUA) and medication-assisted spinal manipulation (MASM) for acute, subacute or chronic low back pain is not recommended.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Manipulation is a procedure and therefore not subject to FDA regulation.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for manipulation under anesthesia. Local Coverage Determinations (LCDs) for Manipulation Under Anesthesia (MUA), exist and compliance with these policies is required where applicable. (Accessed January 11, 2012)

APPLICABLE CODES

The codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document. This list of codes may not be all inclusive.

CPT® Code	Description
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)
22505	Manipulation of spine requiring anesthesia, any region
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
24300	Manipulation, elbow, under anesthesia
25259	Manipulation, wrist, under anesthesia
26340	Manipulation, finger joint, under anesthesia, each joint
27194	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia
27275	Manipulation, hip joint, requiring general anesthesia
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)

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ICD-9 Code (Proven)	Description
718.51	Ankylosis of joint of shoulder region
718.52	Ankylosis of upper arm joint
718.56	Ankylosis of lower leg joint
726.0	Adhesive capsulitis of shoulder
726.10	Unspecified disorders of bursae and tendons in shoulder region
726.11	Calcifying tendinitis of shoulder
733.19	Pathologic fracture of other specified site
805.6	Closed fracture of sacrum and coccyx without mention of spinal cord injury
806.61	Closed fracture of sacrum and coccyx with complete cauda equina lesion
806.62	Closed fracture of sacrum and coccyx with other cauda equina injury

806.79	Open fracture of sacrum and coccyx with other spinal cord injury
808.0	Closed fracture of acetabulum
808.2	Closed fracture of pubis
808.41	Closed fracture of ilium
808.42	Closed fracture of ischium
808.43	Multiple closed pelvic fractures with disruption of pelvic circle
808.44	Multiple closed pelvic fractures without disruption of pelvic circle
808.49	Closed fracture of other specified part of pelvis
808.53	Multiple open pelvic fractures with disruption of pelvic circle
808.54	Multiple open pelvic fractures without disruption of pelvic circle
839.41	Closed dislocation, coccyx
839.42	Closed dislocation, sacrum

ICD-10 Codes (Preview Draft)

In preparation for the transition from ICD-9 to ICD-10 medical coding on **October 1, 2014**, a sample listing of the ICD-10 CM and/or ICD-10 PCS codes associated with this policy has been provided below for your reference. This list of codes may not be all inclusive and will be updated to reflect any applicable revisions to the ICD-10 code set and/or clinical guidelines outlined in this policy. **The effective date for ICD-10 code set implementation is subject to change.*

ICD-10 Diagnosis Code (Effective 10/01/14)	Description
M24.611	Ankylosis, right shoulder
M24.612	Ankylosis, left shoulder
M24.619	Ankylosis, unspecified shoulder
M24.621	Ankylosis, right elbow
M24.622	Ankylosis, left elbow
M24.629	Ankylosis, unspecified elbow
M24.661	Ankylosis, right knee
M24.662	Ankylosis, left knee
M24.669	Ankylosis, unspecified knee
M66.211	Spontaneous rupture of extensor tendons, right shoulder
M66.212	Spontaneous rupture of extensor tendons, left shoulder
M66.219	Spontaneous rupture of extensor tendons, unspecified shoulder
M66.811	Spontaneous rupture of other tendons, right shoulder
M66.812	Spontaneous rupture of other tendons, left shoulder
M66.819	Spontaneous rupture of other tendons, unspecified shoulder
M75.00	Adhesive capsulitis of unspecified shoulder
M75.01	Adhesive capsulitis of right shoulder
M75.02	Adhesive capsulitis of left shoulder
M75.100	Unspecified rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic
M75.101	Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic
M75.102	Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic
M75.30	Calcific tendinitis of unspecified shoulder
M75.31	Calcific tendinitis of right shoulder
M75.32	Calcific tendinitis of left shoulder
M75.50	Bursitis of unspecified shoulder
M75.51	Bursitis of right shoulder
M75.52	Bursitis of left shoulder
M80.011A	Age-related osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture

M80.012A	Age-related osteoporosis with current pathological fracture, left shoulder, initial encounter for fracture
M80.019A	Age-related osteoporosis with current pathological fracture, unspecified shoulder, initial encounter for fracture
M80.041A	Age-related osteoporosis with current pathological fracture, right hand, initial encounter for fracture
M80.042A	Age-related osteoporosis with current pathological fracture, left hand, initial encounter for fracture
M80.049A	Age-related osteoporosis with current pathological fracture, unspecified hand, initial encounter for fracture
M80.811A	Other osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture
M80.812A	Other osteoporosis with current pathological fracture, left shoulder, initial encounter for fracture
M80.819A	Other osteoporosis with current pathological fracture, unspecified shoulder, initial encounter for fracture
M80.841A	Other osteoporosis with current pathological fracture, right hand, initial encounter for fracture
M80.842A	Other osteoporosis with current pathological fracture, left hand, initial encounter for fracture
M80.849A	Other osteoporosis with current pathological fracture, unspecified hand, initial encounter for fracture
M84.411A	Pathological fracture, right shoulder, initial encounter for fracture
M84.412A	Pathological fracture, left shoulder, initial encounter for fracture
M84.419A	Pathological fracture, unspecified shoulder, initial encounter for fracture
M84.441A	Pathological fracture, right hand, initial encounter for fracture
M84.442A	Pathological fracture, left hand, initial encounter for fracture
M84.443A	Pathological fracture, unspecified hand, initial encounter for fracture
M84.444A	Pathological fracture, right finger(s), initial encounter for fracture
M84.445A	Pathological fracture, left finger(s), initial encounter for fracture
M84.446A	Pathological fracture, unspecified finger(s), initial encounter for fracture
M84.454A	Pathological fracture, pelvis, initial encounter for fracture
M84.474A	Pathological fracture, right foot, initial encounter for fracture
M84.475A	Pathological fracture, left foot, initial encounter for fracture
M84.476A	Pathological fracture, unspecified foot, initial encounter for fracture
M84.477A	Pathological fracture, right toe(s), initial encounter for fracture
M84.478A	Pathological fracture, left toe(s), initial encounter for fracture
M84.479A	Pathological fracture, unspecified toe(s), initial encounter for fracture
M84.48XA	Pathological fracture, other site, initial encounter for fracture
M84.511A	Pathological fracture in neoplastic disease, right shoulder, initial encounter for fracture
M84.512A	Pathological fracture in neoplastic disease, left shoulder, initial encounter for fracture
M84.519A	Pathological fracture in neoplastic disease, unspecified shoulder, initial encounter for fracture
M84.541A	Pathological fracture in neoplastic disease, right hand, initial encounter for fracture
M84.542A	Pathological fracture in neoplastic disease, left hand, initial encounter for fracture
M84.549A	Pathological fracture in neoplastic disease, unspecified hand, initial encounter for fracture
M84.550A	Pathological fracture in neoplastic disease, pelvis, initial encounter

	for fracture
M84.574A	Pathological fracture in neoplastic disease, right foot, initial encounter for fracture
M84.575A	Pathological fracture in neoplastic disease, left foot, initial encounter for fracture
M84.576A	Pathological fracture in neoplastic disease, unspecified foot, initial encounter for fracture
M84.611A	Pathological fracture in other disease, right shoulder, initial encounter for fracture
M84.612A	Pathological fracture in other disease, left shoulder, initial encounter for fracture
M84.619A	Pathological fracture in other disease, unspecified shoulder, initial encounter for fracture
M84.641A	Pathological fracture in other disease, right hand, initial encounter for fracture
M84.642A	Pathological fracture in other disease, left hand, initial encounter for fracture
M84.649A	Pathological fracture in other disease, unspecified hand, initial encounter for fracture
M84.650A	Pathological fracture in other disease, pelvis, initial encounter for fracture
M84.674A	Pathological fracture in other disease, right foot, initial encounter for fracture
M84.675A	Pathological fracture in other disease, left foot, initial encounter for fracture
M84.676A	Pathological fracture in other disease, unspecified foot, initial encounter for fracture
M84.68XA	Pathological fracture in other disease, other site, initial encounter for fracture
M99.14	Subluxation complex (vertebral) of sacral region
S32.10XA	Unspecified fracture of sacrum, initial encounter for closed fracture
S32.10XB	Unspecified fracture of sacrum, initial encounter for open fracture
S32.110A	Nondisplaced Zone I fracture of sacrum, initial encounter for closed fracture
S32.111A	Minimally displaced Zone I fracture of sacrum, initial encounter for closed fracture
S32.112A	Severely displaced Zone I fracture of sacrum, initial encounter for closed fracture
S32.119A	Unspecified Zone I fracture of sacrum, initial encounter for closed fracture
S32.120A	Nondisplaced Zone II fracture of sacrum, initial encounter for closed fracture
S32.121A	Minimally displaced Zone II fracture of sacrum, initial encounter for closed fracture
S32.122A	Severely displaced Zone II fracture of sacrum, initial encounter for closed fracture
S32.129A	Unspecified Zone II fracture of sacrum, initial encounter for closed fracture
S32.130A	Nondisplaced Zone III fracture of sacrum, initial encounter for closed fracture
S32.131A	Minimally displaced Zone III fracture of sacrum, initial encounter for closed fracture
S32.132A	Severely displaced Zone III fracture of sacrum, initial encounter for closed fracture
S32.139A	Unspecified Zone III fracture of sacrum, initial encounter for closed

	fracture
S32.14XA	Type 1 fracture of sacrum, initial encounter for closed fracture
S32.15XA	Type 2 fracture of sacrum, initial encounter for closed fracture
S32.16XA	Type 3 fracture of sacrum, initial encounter for closed fracture
S32.17XA	Type 4 fracture of sacrum, initial encounter for closed fracture
S32.19XA	Other fracture of sacrum, initial encounter for closed fracture
S32.2XXA	Fracture of coccyx, initial encounter for closed fracture
S32.2XXB	Fracture of coccyx, initial encounter for open fracture
S32.301A	Unspecified fracture of right ilium, initial encounter for closed fracture
S32.302A	Unspecified fracture of left ilium, initial encounter for closed fracture
S32.309A	Unspecified fracture of unspecified ilium, initial encounter for closed fracture
S32.311A	Displaced avulsion fracture of right ilium, initial encounter for closed fracture
S32.312A	Displaced avulsion fracture of left ilium, initial encounter for closed fracture
S32.313A	Displaced avulsion fracture of unspecified ilium, initial encounter for closed fracture
S32.314A	Nondisplaced avulsion fracture of right ilium, initial encounter for closed fracture
S32.315A	Nondisplaced avulsion fracture of left ilium, initial encounter for closed fracture
S32.316A	Nondisplaced avulsion fracture of unspecified ilium, initial encounter for closed fracture
S32.391A	Other fracture of right ilium, initial encounter for closed fracture
S32.392A	Other fracture of left ilium, initial encounter for closed fracture
S32.399A	Other fracture of unspecified ilium, initial encounter for closed fracture
S32.401A	Unspecified fracture of right acetabulum, initial encounter for closed fracture
S32.402A	Unspecified fracture of left acetabulum, initial encounter for closed fracture
S32.409A	Unspecified fracture of unspecified acetabulum, initial encounter for closed fracture
S32.411A	Displaced fracture of anterior wall of right acetabulum, initial encounter for closed fracture
S32.412A	Displaced fracture of anterior wall of left acetabulum, initial encounter for closed fracture
S32.413A	Displaced fracture of anterior wall of unspecified acetabulum, initial encounter for closed fracture
S32.414A	Nondisplaced fracture of anterior wall of right acetabulum, initial encounter for closed fracture
S32.415A	Nondisplaced fracture of anterior wall of left acetabulum, initial encounter for closed fracture
S32.416A	Nondisplaced fracture of anterior wall of unspecified acetabulum, initial encounter for closed fracture
S32.421A	Displaced fracture of posterior wall of right acetabulum, initial encounter for closed fracture
S32.422A	Displaced fracture of posterior wall of left acetabulum, initial encounter for closed fracture
S32.423A	Displaced fracture of posterior wall of unspecified acetabulum, initial encounter for closed fracture
S32.424A	Nondisplaced fracture of posterior wall of right acetabulum, initial encounter for closed fracture

S32.425A	Nondisplaced fracture of posterior wall of left acetabulum, initial encounter for closed fracture
S32.426A	Nondisplaced fracture of posterior wall of unspecified acetabulum, initial encounter for closed fracture
S32.431A	Displaced fracture of anterior column [iliopubic] of right acetabulum, initial encounter for closed fracture
S32.432A	Displaced fracture of anterior column [iliopubic] of left acetabulum, initial encounter for closed fracture
S32.433A	Displaced fracture of anterior column [iliopubic] of unspecified acetabulum, initial encounter for closed fracture
S32.434A	Nondisplaced fracture of anterior column [iliopubic] of right acetabulum, initial encounter for closed fracture
S32.435A	Nondisplaced fracture of anterior column [iliopubic] of left acetabulum, initial encounter for closed fracture
S32.436A	Nondisplaced fracture of anterior column [iliopubic] of unspecified acetabulum, initial encounter for closed fracture
S32.441A	Displaced fracture of posterior column [ilioischial] of right acetabulum, initial encounter for closed fracture
S32.442A	Displaced fracture of posterior column [ilioischial] of left acetabulum, initial encounter for closed fracture
S32.443A	Displaced fracture of posterior column [ilioischial] of unspecified acetabulum, initial encounter for closed fracture
S32.444A	Nondisplaced fracture of posterior column [ilioischial] of right acetabulum, initial encounter for closed fracture
S32.445A	Nondisplaced fracture of posterior column [ilioischial] of left acetabulum, initial encounter for closed fracture
S32.446A	Nondisplaced fracture of posterior column [ilioischial] of unspecified acetabulum, initial encounter for closed fracture
S32.451A	Displaced transverse fracture of right acetabulum, initial encounter for closed fracture
S32.452A	Displaced transverse fracture of left acetabulum, initial encounter for closed fracture
S32.453A	Displaced transverse fracture of unspecified acetabulum, initial encounter for closed fracture
S32.454A	Nondisplaced transverse fracture of right acetabulum, initial encounter for closed fracture
S32.455A	Nondisplaced transverse fracture of left acetabulum, initial encounter for closed fracture
S32.456A	Nondisplaced transverse fracture of unspecified acetabulum, initial encounter for closed fracture
S32.461A	Displaced associated transverse-posterior fracture of right acetabulum, initial encounter for closed fracture
S32.462A	Displaced associated transverse-posterior fracture of left acetabulum, initial encounter for closed fracture
S32.463A	Displaced associated transverse-posterior fracture of unspecified acetabulum, initial encounter for closed fracture
S32.464A	Nondisplaced associated transverse-posterior fracture of right acetabulum, initial encounter for closed fracture
S32.465A	Nondisplaced associated transverse-posterior fracture of left acetabulum, initial encounter for closed fracture
S32.466A	Nondisplaced associated transverse-posterior fracture of unspecified acetabulum, initial encounter for closed fracture
S32.471A	Displaced fracture of medial wall of right acetabulum, initial encounter for closed fracture
S32.472A	Displaced fracture of medial wall of left acetabulum, initial encounter

	for closed fracture
S32.473A	Displaced fracture of medial wall of unspecified acetabulum, initial encounter for closed fracture
S32.474A	Nondisplaced fracture of medial wall of right acetabulum, initial encounter for closed fracture
S32.475A	Nondisplaced fracture of medial wall of left acetabulum, initial encounter for closed fracture
S32.476A	Nondisplaced fracture of medial wall of unspecified acetabulum, initial encounter for closed fracture
S32.481A	Displaced dome fracture of right acetabulum, initial encounter for closed fracture
S32.482A	Displaced dome fracture of left acetabulum, initial encounter for closed fracture
S32.483A	Displaced dome fracture of unspecified acetabulum, initial encounter for closed fracture
S32.484A	Nondisplaced dome fracture of right acetabulum, initial encounter for closed fracture
S32.485A	Nondisplaced dome fracture of left acetabulum, initial encounter for closed fracture
S32.486A	Nondisplaced dome fracture of unspecified acetabulum, initial encounter for closed fracture
S32.491A	Other specified fracture of right acetabulum, initial encounter for closed fracture
S32.492A	Other specified fracture of left acetabulum, initial encounter for closed fracture
S32.499A	Other specified fracture of unspecified acetabulum, initial encounter for closed fracture
S32.501A	Unspecified fracture of right pubis, initial encounter for closed fracture
S32.502A	Unspecified fracture of left pubis, initial encounter for closed fracture
S32.509A	Unspecified fracture of unspecified pubis, initial encounter for closed fracture
S32.511A	Fracture of superior rim of right pubis, initial encounter for closed fracture
S32.512A	Fracture of superior rim of left pubis, initial encounter for closed fracture
S32.519A	Fracture of superior rim of unspecified pubis, initial encounter for closed fracture
S32.591A	Other specified fracture of right pubis, initial encounter for closed fracture
S32.592A	Other specified fracture of left pubis, initial encounter for closed fracture
S32.599A	Other specified fracture of unspecified pubis, initial encounter for closed fracture
S32.601A	Unspecified fracture of right ischium, initial encounter for closed fracture
S32.602A	Unspecified fracture of left ischium, initial encounter for closed fracture
S32.609A	Unspecified fracture of unspecified ischium, initial encounter for closed fracture
S32.611A	Displaced avulsion fracture of right ischium, initial encounter for closed fracture
S32.612A	Displaced avulsion fracture of left ischium, initial encounter for closed fracture
S32.613A	Displaced avulsion fracture of unspecified ischium, initial encounter

	for closed fracture
S32.614A	Nondisplaced avulsion fracture of right ischium, initial encounter for closed fracture
S32.615A	Nondisplaced avulsion fracture of left ischium, initial encounter for closed fracture
S32.616A	Nondisplaced avulsion fracture of unspecified ischium, initial encounter for closed fracture
S32.691A	Other specified fracture of right ischium, initial encounter for closed fracture
S32.692A	Other specified fracture of left ischium, initial encounter for closed fracture
S32.699A	Other specified fracture of unspecified ischium, initial encounter for closed fracture
S32.810A	Multiple fractures of pelvis with stable disruption of pelvic ring, initial encounter for closed fracture
S32.810B	Multiple fractures of pelvis with stable disruption of pelvic ring, initial encounter for open fracture
S32.811A	Multiple fractures of pelvis with unstable disruption of pelvic ring, initial encounter for closed fracture
S32.811B	Multiple fractures of pelvis with unstable disruption of pelvic ring, initial encounter for open fracture
S32.82XA	Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for closed fracture
S32.82XB	Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for open fracture
S32.89XA	Fracture of other parts of pelvis, initial encounter for closed fracture
S32.9XXA	Fracture of unspecified parts of lumbosacral spine and pelvis, initial encounter for closed fracture
S33.2XXA	Dislocation of sacroiliac and sacrococcygeal joint, initial encounter
S34.131A	Complete lesion of sacral spinal cord, initial encounter
S34.132A	Incomplete lesion of sacral spinal cord, initial encounter
S34.3XXA	Injury of cauda equina, initial encounter

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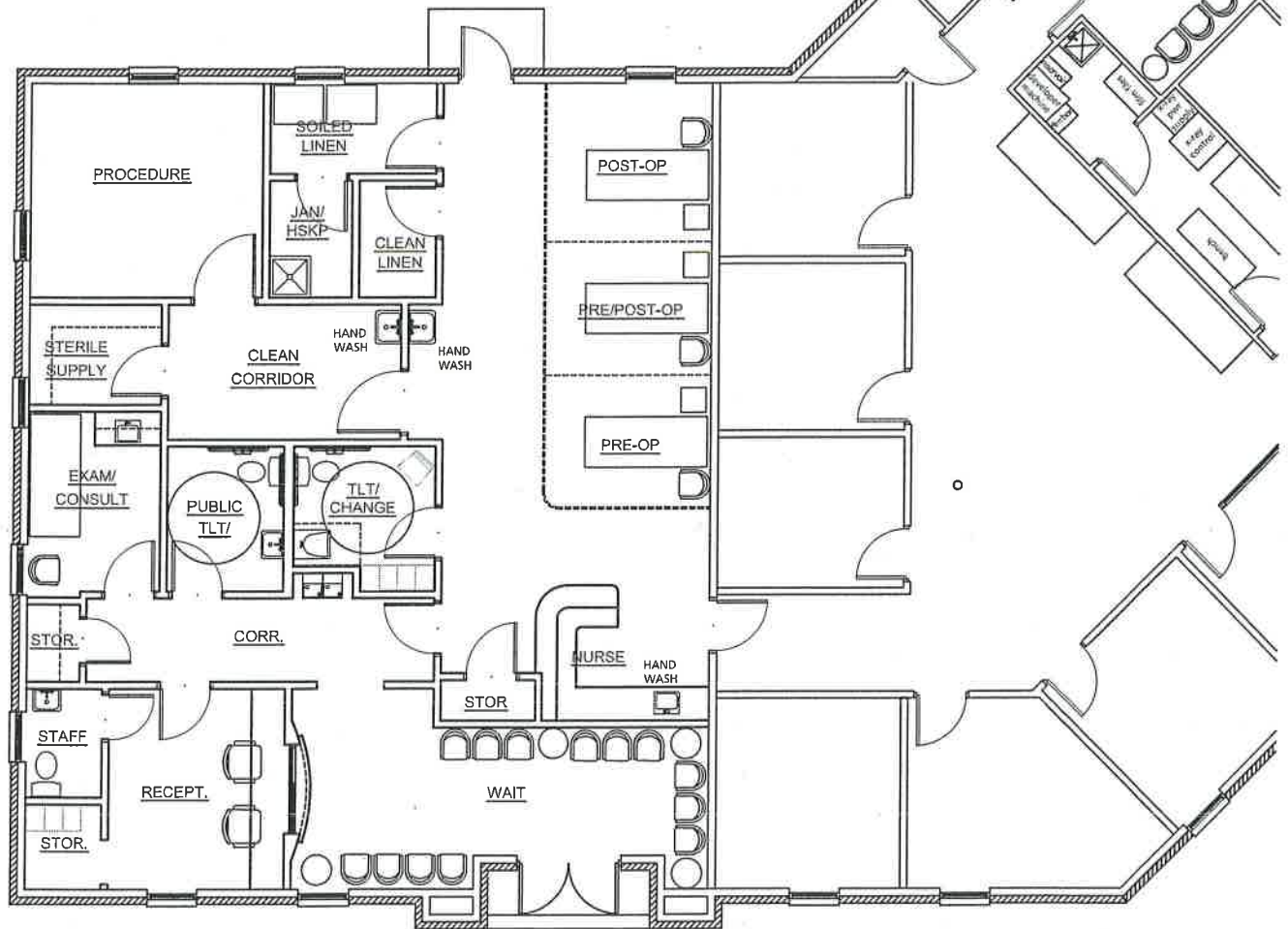
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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
09/01/2012	<ul style="list-style-type: none"> Added list of applicable ICD-10 codes (preview draft) in preparation for the transition from ICD-9 to ICD-10 medical coding on 10/01/14
05/01/2012	<ul style="list-style-type: none"> Updated description of services to reflect most current clinical evidence, CMS information and references; no change to coverage rationale Updated list of applicable (proven) ICD-9 diagnosis codes; added 808.44 and 808.53 Archived previous policy version 2011T0515E

URBANARCH
ASSOCIATES, P.C.

ARCHITECTURE

PLANNING

RESEARCH

498 SOUTH MAIN
MEMPHIS, TN 38103P 901.578.7173
F 901.578.5223

SPINAL HEALTHCARE ASSOC, P.C. AMBULATORY SURGERY CENTER FLOORPLAN

PROJECT NO: 12069
DRAWING: PRELIM PLAN OPTION 1
SCALE: 3/32"=1'-0"

DATE: 11-1-12

SHEET: A1

February 11, 2013
12:55pm



BAPTIST

MEMORIAL MEDICAL GROUP
MEMPHIS HOSPITALISTS

6027 Walnut Grove Road, Suite 214
Memphis, TN 38120
901-226-3190

February 22, 2012

To Whom It May Concern:

The hospitalists of Baptist Memorial Medical Group will admit patients meeting inpatient criteria to Baptist Memorial Hospital-Memphis, for patients of the Spinal Health Care Associates/Cordova Pain Treatment Center.

Upon discharge, these patients will be instructed to follow up with the above named providers.

This letter shall be effective for up to two (2) years from the date of this letter. Should you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

John W. Fowler, Jr, MD FACP
Medical Director


STATE OF TENNESSEE
DIVISION OF HEALTH RELATED BOARDS

EXPIRATION DATE: 03/31/2015
LICENSE NO: DC00000002633
RENEWAL NO: 608660

THIS IS TO CERTIFY THAT:
JAMES T WILSON II
IS A DULY LICENSED
CHIROPRACTIC PHYSICIAN
IN THE STATE OF TENNESSEE AS REQUIRED BY THE
TENNESSEE CODE ANNOTATED.

Rosemarie OHO
DIRECTOR, HEALTH RELATED BOARDS

J. Wilson DC
SIGNATURE



From:

11/21/2011 18:12

#789 P.003/013

Renewal No 34656


State of Tennessee
Division of Health Related Boards

This Certifies that
LOLITA L. HORTON
whose credentials have been approved by the
BOARD OF NURSING
has fulfilled all requirements for renewal and registration as
required by the Tennessee Code Annotated and is a duly
authorized ADVANCED PRACTICE NURSE
in the State of Tennessee through AUGUST 31, 2013

License No APN0000011700

VALID IN TN ONLY

NURSE PRACTITIONER WITH CERTIFICATE OF FITNESS



Renewal No.
766852

State of Tennessee
Division Of Health Related Boards

8104948
License No.
MD0000012446

This Certifies that
DAVID G CRAWFORD, MD
whose credentials have been approved by the:
BOARD OF MEDICAL EXAMINERS
has fulfilled all requirements for renewal and registration as
required by the Tennessee Code Annotated and is a duly
authorized: MEDICAL DOCTOR
in the State of Tennessee through **MAY 31, 2014**



Boemaris OHO
DIRECTOR, HEALTH-RELATED BOARDS



Renewal No.
608390

State of Tennessee
Division of Health-Related Boards

80688887
DC0000001755

This Certifies that

JASON DONN COLEMAN

whose credentials have been approved by the:

BOARD OF CHIROPRACTIC EXAMINERS
has fulfilled all requirements for renewal and registration as
required by the Tennessee Code Annotated and is a duly
authorized CHIROPRACTIC PHYSICIAN
in the State of Tennessee through JULY 31, 2014

Jason D Coleman
Director, Health-Related Boards

060614 12139

SUPPLEMENTAL- # 1

February 11, 2013

12:55pm

STATE OF TENNESSEE
DIVISION OF HEALTH CARE ABUSE BOARD

EXPIRATION DATE: 10/31/2014
LICENSE NO: EC0000000830
RENEWAL NO: 008832

THIS IS TO CERTIFY THAT:
BOCK WOOSTER DO
IS A DUTY LICENSEE
CHIROPRACTIC PHYSICIAN
IN THE STATE OF TENNESSEE AS REQUIRED BY THE
TENNESSEE CODE ANNOTATED

[Signature]
DIRECTOR, HEALTH RELATED BOARDS




[Signature]
SIGNATURE



Renewal No. 40083 State of Tennessee License No. 8252687
Division Of Health Related Boards APN0000016937

This Certifies that **LACHANDRA MCCORD** VALID IN TN ONLY
whose credentials have been approved by the:
BOARD OF NURSING
has fulfilled all requirements for renewal and registration as
required by the Tennessee Code Annotated and is a duly
authorized: **ADVANCED PRACTICE NURSE**
in the State of Tennessee through **AUGUST 31, 2013**

NURSE PRACTITIONER WITH CERTIFICATE OF FITNESS

  
DIRECTOR, HEALTH-RELATED BOARDS

February 11, 2013

4:55pm

Renewal No.
38451

State of Tennessee

Division of Health Related Boards

APR0000016744

8/30/27 NG

This Certifies that

BRENDA D BAILEY

VALID IN TN ONLY

whose credentials have been approved by the:

BOARD OF NURSING

has fulfilled all requirements for renewal and registration as
required by the Tennessee Code Annotated and is a duly
authorized: ADVANCED PRACTICE NURSE
in the State of Tennessee through NOVEMBER 30, 2013

NURSE PRACTITIONER WITH CERTIFICATE OF FITNESS



Opemerie CHD
DIRECTOR, HEALTH RELATED BOARDS

007014

12257

Renewal No.
439075State of Tennessee
Division of Health Related Boards8293254
License No.
PT0000006105

This Certifies that

MELANIE ANN WRIGHT

BOARD OF PHYSICAL THERAPY

whose credentials have been approved by the
has fulfilled all requirements for renewal and registration as
authorized physical therapist

in the State of Tennessee through OCTOBER 31, 2014

Pamela C. H. O.
Director, Division of Health Related Boards



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
Bureau of Health Licensure and Regulation
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place
Nashville, TN 37243

1108/007-600

PHIL BREDESEN
GOVERNOR

SUSAN R. COOPER, MSN, RN.
COMMISSIONER

Board of Chiropractic Examiners

AGREED CITATION

Name: Rock Wooster DC
License #: 830

WHEREAS, Respondent is licensed as a chiropractic physician in the State of Tennessee by the Tennessee Board of Chiropractic Examiners, license number 830; and

WHEREAS, Respondent has failed to properly maintain sufficient continuing education credits in violation of Tenn. Code Ann. §63-4-112; §63-4-114(1); and Rule 0260-2-.12 of **TENN. COMP. R. & REGS**; and

WHEREAS, Respondent admits that this violation occurred and does not wish for this matter to be further prosecuted by the State of Tennessee; and

WHEREAS, Respondent acknowledges that Respondent is aware that he or she has a right to a hearing before the Tennessee Board of Chiropractic Examiners. At such hearing, Respondent acknowledges that he or she is aware that he or she may be represented by counsel if he or she so chooses. Moreover, Respondent acknowledges and is fully aware that no civil penalty may be assessed against him or her and no formal action may be taken against his or her license without being provided the opportunity for a hearing before the Tennessee Board of Chiropractic Examiners. Respondent acknowledges and understands that by signing this Agreed Citation and paying a civil penalty of Six Hundred Dollars (\$600.00) and providing proof of completion of the required number of continuing education credits within ninety (90) days from the date of receipt of this Agreed Citation. The Respondent waives his or her right to a hearing as described herein and provided for in the Administrative Procedures Act found at Tenn. Code Ann. § 4-5-301 et seq.; and

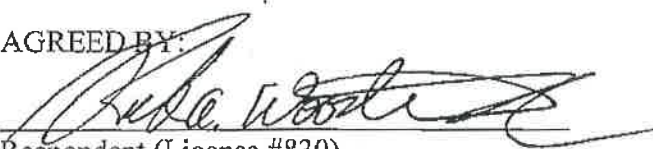
WHEREAS, Respondent admits to the failure to obtain twelve (12) hours of the required

twenty-four (24) continuing education credits for 2009; and


WHEREAS, Respondent acknowledges and understands that if the Respondent does not sign this citation and return it along with a check or money order made out to the State of Tennessee for the prescribed amount within thirty (30) days, then a formal contested case proceeding could be initiated in which the Tennessee Board of Chiropractic Examiners is authorized to assess civil penalties of up to one thousand dollars (\$1,000.00) for each violation of applicable law and the Board could refuse to renew the Respondent's license or the Respondent's license could be suspended or revoked; and

THEREFORE, Respondent, by signing below, voluntarily agrees to the terms of this citation and herewith remits a civil penalty in the amount of Six Hundred Dollars (\$600.00). The Respondent further agrees to provide proof to the Board of completion of twelve (12) hours of continuing education, the amount determined to be deficient within **ninety (90) days** of ratification of this citation by the Board. Furthermore, Respondent executes this citation for the sole purpose of avoiding further administrative proceedings with respect to this violation. Respondent hereby expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to challenge or contest the validity of this citation. Respondent acknowledges that this citation is subject to Board approval and agrees that consideration of this citation shall not prejudice the Board in any future proceeding should the Board not approve this citation.

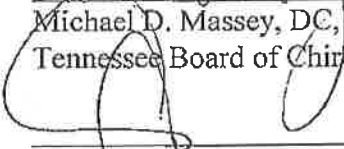
AGREED BY:


Respondent (License #830)


Date


Michael D. Massey, DC, President
Tennessee Board of Chiropractic Examiners


Date


Andrea Huddleston Esq., Assistant General Counsel
Tennessee Department of Health


Date

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.
- All projects should have a project cost of at least \$3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
- The cost of any lease should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater.
- The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
- For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.

Response: The Project Costs Chart is completed. This Application includes the fair market value (FMV) of the space at the new specialty ASTC location (actual lease amount is approximately \$144,000 for 3 years, which is lower than the FMV of \$286,667), equipment costs, and legal and administrative fees. The 2,100 GSF facility will be renovated for a total cost of \$110,000, which amounts to approximately \$52.39 per GSF. Considering these conservative projections, the relatively low cost of this project is very reasonable when compared to recent ASTC CON applications.

According to data compiled by the Health Services and Development Agency, ASTC renovation costs vary from an average 1st Quartile of \$40.09/sq. ft., to an average Median Quartile of \$100.47/sq.ft., to an average 3rd Quartile of \$195.00/sq.ft. These figures are evidently averages from approved CON applications for years 2009 through 2011, and reflect the latest data on the HSDA website. Our estimate of \$52.39 per GSF compares favorably to these average JAR figures.

Please see *Attachment B.II.A.2* for a letter from the contractor.

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase.

1. Architectural and Engineering Fees	\$ 3,000 00
2. Legal, Administrative (Excluding CON Filing Fee), Consultant	30,000 00
3. Acquisition of Site	
4. Preparation of Site	10,000 00
5. Construction Costs (Possible Renovation)	100,000 00
6. Contingency Fund	
7. Fixed Equipment (Not included in Construction Contract)	
8. Moveable Equipment (List all equipment over \$50,000) (NONE OVER \$50K)	40,000 00
9. Other (Specify)	

Subsection A Total 183,000 00

B. Acquisition by gift, donation, or lease.

1. Facility (Inclusive of Building and Land) (Estimated FMV)	286,667 00
2. Building Only	
3. Land Only	
4. Equipment (Specify)	
5. Other (Specify)	

Subsection B Total 286,667 00

C. Financing costs and fees

1. Interim Financing	
2. Underwriting Costs	
3. Reserve for One Year's Debt Service	
4. Other (Specify)	

Subsection C Total 0 00

D. Estimated Project Cost (A + B + C)	\$ <u>469,667.00</u>
E. CON Filing Fee	\$ <u>3,000.00</u>
F. Total Estimated Project Cost (D + E)	TOTAL \$ <u>472,667.00</u>

* estimated FMV will be paid by (lower) rental costs over time and are considered operational costs; therefore, the only "new" money required for the project is less than total listed above.

PROJECTED DATA CHART

SUPPLEMENTAL- # 1

February 11, 2013

Give information for the two (2) years following the completion of this project. The fiscal year begins **January** (month).

2013 FEB 11 PM 1:09

Yr-2

A.	Utilization/Occupancy Rate (<i>surgical patients</i>)	<u>130</u>	<u>170</u>
B.	Revenue from Services to Patients		
	1. Inpatient Services	<u>1,950,000</u>	<u>2,550,000</u>
	2. Outpatient Services		
	3. Emergency Services		
	4. Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	<u>1,950,000</u>	<u>2,550,000</u>
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	<u>987,500</u>	<u>1,275,000</u>
	2. Provision for Charity Care	<u>108,625</u>	<u>137,500</u>
	3. Provision for Bad Debt	<u>98,750</u>	<u>127,500</u>
	Total Deductions	<u>1,194,875</u>	<u>1,540,000</u>
	NET OPERATING REVENUE	<u>755,125</u>	<u>1,010,000</u>
D.	Operating Expenses		
	1. Salaries and Wages	<u>151,120</u>	<u>154,400</u>
	2. Physician's Salaries and Wages (All Medical Practitioners)	<u>210,000</u>	<u>223,000</u>
	3. Supplies	<u>23,000</u>	<u>28,000</u>
	4. Taxes	<u>18,000</u>	<u>20,000</u>
	5. Depreciation	<u>10,000</u>	<u>10,000</u>
	6. Rent	<u>48,000</u>	<u>48,000</u>
	7. Interest, other than Capital		
	8. Management Fees		
	a. Fees to Affiliates		
	b. Fees to non-Affiliates		
	9. Other Expenses (Specify) <u>See following page</u>	<u>98,800</u>	<u>100,600</u>
	Total Operating Expenses	<u>558,920</u>	<u>584,000</u>
E.	Other Revenue (Expenses)-Net (Specify)		
	NET OPERATING INCOME (LOSS)	<u>196,205</u>	<u>426,000</u>
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest (on Letter of Credit)		
	Total Capital Expenditure		
	NET OPERATING INCOME (LOSS) LESS		
	CAPITAL EXPENDITURES	<u>196,205</u>	<u>426,000</u>

OTHER EXPENSES
(line D.8, Projected Data Chart)

SUPPLEMENTAL- # 1

February 11, 2013
12:55pm

Other Expenses	Yr-1	Yr-2
Insurance	12,000	13,500
Utilities	2,400	2,700
Accounting	6,000	6,000
Computer Consulting	2,400	2,400
Bank Fees	1,500	1,500
Permits/Licenses	12,500	12,500
Training/Seminars	10,000	10,000
Purchased Services	12,000	12,000
Equipment	16,000	16,000
Janitorial	24,000	24,000
TOTAL (line D.8)	98,800	100,600

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

SUPPLEMENTAL # 1

**February 11, 2013
12:55pm**

Response: See (rounded) projected figures below for Year 1:

\$	15,000	Average Gross Charge per procedure
\$	9,191	Average Deduction from Operating Revenue per procedure
\$	5,809	Average Net Charge per procedure.

The above charges are global charges. No post-outpatient MUA services are required.

Again, patients will be charged one fee, but this one fee is for a three-day process. The procedure is completed in 3 days in a row as a way of controlling arthrokinetic dyskensia which has caused fibroblastic proliferative changes. (Please refer to Chapter 2 of Gordon, R. "Manipulation Under Anesthesia, Concepts In Theory and Application"). Since the reference states that adhesions (fibroblastic proliferative changes) will reform in 24-48 hours if left unattended (Guyton, Alter, Koltke), serial MUA performed successively in a three-day format, completed independently on each of the successive days, is how this procedure releases the adhesion proliferation, and continues to resolve the patients aberrant biomechanical pathology.

SUPPLEMENTAL # 1
February 11, 2013
12:55pm

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: There are no current charges. See (rounded) projected figures below for Year 1:

\$	15,000	Average Gross Charge per procedure
\$	9,191	Average Deduction from Operating Revenue per procedure
\$	5,809	Average Net Charge per procedure.

The above charges are global charges. No post-outpatient MUA services are required.

Again, patients will be charged one fee, but this one fee is for a three-day process. The procedure is completed in 3 days in a row as a way of controlling arthrokinetic dyskensia which has caused fibroblastic proliferative changes. (Please refer to Chapter 2 of Gordon, R. "Manipulation Under Anesthesia, Concepts In Theory and Application"). Since the reference states that adhesions (fibroblastic proliferative changes) will reform in 24-48 hours if left unattended (Guyton, Alter, Koltke), serial MUA performed successively in a three-day format, completed independently on each of the successive days, is how this procedure releases the adhesion proliferation, and continues to resolve the patients aberrant biomechanical pathology.

ORIGINAL- SUPPLEMENTAL-2

**Spinal Healthcare Associates, PC
CN1212-060**

SUPPLEMENTAL- # 2

**February 14, 2013
12:55pm**

WEEKS & ANDERSON

An Association of Attorneys

**2021 RICHARD JONES ROAD, SUITE 350
NASHVILLE, TENNESSEE 37215-2874
TELEPHONE 615/383-3332
FACSIMILE 615/383-3480**

2013 FEB 14 PM 12:54

KENT M. WEEKS
ROBERT A. ANDERSON

F. B. MURPHY, JR.
E. GRAHAM BAKER, JR.

DIRECT TELEPHONE NUMBER: 615/370-3380

February 14, 2013

Phillip M. Earhart
Health Services Development Examiner
Tennessee Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Supplemental Information: Certificate of Need Application CN1212-060
Spinal Healthcare Associates, PC

Dear Phillip:

Enclosed are three (3) copies of responses to your second supplemental questions regarding the referenced Certificate of Need application. If you have any additional questions, please contact me.

Sincerely,


E. Graham Baker, Jr.
/np

Enclosures as noted

**February 14, 2013
12:55pm**

AFFIDAVIT

2013 FEB 14 PM 12: 54

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY: Spinal Healthcare Associates, PC (CN1212-060)

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.



Signature/Title Attorney at Law

Sworn to and subscribed before me, a Notary Public, this 14th day of February, 2013; witness my hand at office in the County of Davidson, State of Tennessee.



NOTARY PUBLIC
My Commission expires May 6, 2013



1. Section B, Project Description, Item I

The billable CPT codes for MUJA procedures are noted. However, clarification is needed. The applicant stated no estimates of MUJA procedures were included in projecting income/expenses for this application. The CPT codes provided in the supplemental response appear to be common codes that are not limited to MUA procedures. According to statute, the agency may approve all or part of an application. For this purpose please complete the following tables for Year One of the proposed project:

MUJA Procedures

CPT Code	Procedure Description	Reimbursement by Payor Type			
		TennCare*	Medicare	Commercial	Other
64490	cervical/thoracic injection level 1	\$165.00	\$302.36	\$550.00	195.73
64491	cervical/thoracic injection level 2	82.44	97.60	500.00	97.21
64492	cervical/thoracic injection level 3	83.39	97.60	500.00	98.22
64493	Lumbar injection level 1	145.18	302.36	550.00	174.71
64494	Lumbar injection level 2	74.92	97.60	500.00	87.86
64495	Lumbar injection level 3	75.87	97.60	500.00	89.21
20605	intermediate joint (wrist, elbow, ankle)	70.00	19.76	75.93	50.99
20610	Major Joint(shoulder, hip, knee)	70.00	20.48	100.39	67.42
27096	SI injection	407.76	302.36	242.89	163.14
20552	TPI 1-2 muscles	56.46	21.67	68.92	46.29
20553	TPI 3 or more muscles	56.46	25.72	78.05	52.42
Other					
Total		\$	\$	\$	\$

* There are no "TennCare" reimbursement amounts. Each MCO develops its own reimbursement amounts, and the amounts shown are the averages (that could be ascertained) by the various TennCare MCOs.

MUA Procedures

2013 FEB 14 PM 12:54

CPT Code	Procedure Description	Reimbursement by Payor Type			
		TennCare*	Medicare	Commercial	Other
21073	MUA TMJ	\$284.34	\$182.64	\$468.85	\$333.78
22505	MUA SPINE	193.67	555.33	172.76	103.09
23700	MUA Shoulder	191.27	555.33	257.51	166.71
24300	MUA Elbow	318.04	555.33	437.08	344.78
25259	MUA Wrist	314.98	446.48	432.20	346.89
26340	MUA Finger	240.15	213.17	330.04	278.43
27194	MUA Pelvic	619.12	555.33	709.43	601.02
27275	MUA Hip	182.03	555.33	218.96	153.14
27570	MUA Knee	152.74	555.33	192.61	127.74
27860	MUA Ankle	184.48	555.33	207.88	151.77
Other					
Total		\$	\$	\$	\$

* There are no "TennCare" reimbursement amounts. Each MCO develops its own reimbursement amounts, and the amounts shown are the averages (that could be ascertained) by the various TennCare MCOs.

If needed, please revise the projected data chart and resubmit after completing the above chart.

Please clarify if the applicant will use the C-Arm fluoroscopic system for billable codes 64490-64495.

Response: The above charts are completed, as best they can be. First, there are no TennCare reimbursement rates for the requested CPT codes. Each MCO develops its own reimbursement rate schedules. The amounts given in the first chart for "TennCare" are averages that could be determined by existing MCOs.

Second, the Applicant has stated multiple times that its projected income and expense chart does not include separate charges for MUJA. Again, MUJA is a part of MUA, and the Applicant will charge a global fee for MUA. Therefore, there will be no separate charges for MUJA – all MUJA "charges" will be a part of the global \$15,000 charge for MUA procedures. While there may be separate charges available for the various CPT codes requested, anesthesiologist fees, professional fees, supplies fees, etc., the Applicant will charge one global fee per patient for MUA.

The comment that "[A]ccording to statute, the agency may approve all or part of an application." is confusing, at best, to the Applicant. The literature is replete that MUJA is a part of MUA. In fact, insurance companies insist that MUJA procedures are required initial steps prior to providing the more aggressive procedures in MUA. Therefore, "MUA" is a two-step process that includes (1) attempting joint injections first (also called MUJA) to see if such injections alleviate the patient's problem, prior to (2) utilizing general anesthesia and performing

manipulation on that patient. The reviewer's attention is again directed to attachments *BCBST-MUA* and *UHC-MUA Policy* which were included in the first set of supplemental responses.

Evidently, some providers nationwide bill for separate procedures, but the Applicant will have one global fee, which fee includes all costs for both the preliminary joint injections and the more progressive manipulation under anesthesia.

Finally, the fees given are from those carriers from which fees could be ascertained. The Applicant is not currently contracted with any of the carriers, and fee schedules are not routinely available to providers who are not contracted. The data that was ultimately retrieved are estimates given from the carriers, but the actual amounts, when contracted, may be a little higher.

As always, insurance companies, Medicare and TennCare MCOs will pay what they will pay. It is anticipated that such reimbursement will be sufficient to maintain economic feasibility of the project.

Once again, there is no need for a new or revised Projected Data Chart. The reviewer's insistence that we bill for separate items is perplexing to the Applicant. The Applicant will charge a global fee, and all "charges" – for MUJA, for manipulation under anesthesia, for anesthesiologists, for professional fees, supplies, and for anything else – are included in the \$15,000 charge already given.

As stated in the application and the first set of supplementals, the Applicant will utilize the C-arm for injection placement for MUJA procedures. The C-Arm is a fixed, permanently-installed fluoroscopic system. The imaging system allows easy positioning with adequate space to work around and a wide range of motion. The C-arm will be utilized for injection placement for MUJA procedures. It is not utilized during more progressive MUA procedures. There is no separate charge. The Applicant will charge one global fee.

2. Economic Feasibility, Item 4, Projected Data Chart

The response from the applicant on how one fee will be charged to patients is noted. However, further clarification is needed. The applicant states the same rates were used for MUA's approved by the HSDA in both the Nashville and Knoxville facilities. Please clarify if mentioned MUJA joint procedure reimbursement was included in this fee. Even though the applicant adopted the same rates from the Nashville and Knoxville facilities, the applicant should explain how this fee is calculated. Please explain.

Please complete the following table:

Type of Surgery	Year 1 # of surgical cases	Year 2 # of surgical cases	Year One Gross Revenue	Year Two Gross Revenue
MUJA	?	?	0	0
MUA	130	170	1,950,000	2,550,000
Total	130	170	1,950,000	2,550,000

Response: The above chart is completed. As stated repeatedly, the Applicant anticipates treating 130 patients in Year 1 and 170 patients in Year 2, and the global charge of \$15,000 per patient results in gross revenue fees of \$1,950,000 in Year 1 and \$2,550,000 in Year 2. These numbers are included on the Projected Data Chart. They have not changed. All charges, whether for MUJA, professional fees, anesthesiologist fees, and the like, are included in the global charge of \$15,000 per patient. The Projected Data Chart does not need to be revised.

The Applicant has not projected, and cannot project, how many patients will require MUJA prior to proceeding with more aggressive procedures. This will be determined later on a case-by-case basis according to the medical needs of the patient and the requirements of the insurance carriers. In any event, there will be no additional gross revenue for MUJA procedures, as the Applicant will charge one global fee per patient.

As stated earlier in the first set of supplementals, the Applicant first ascertained that the usual and customary charge rate of \$15,000 was contained in both applications for the two other MUA applications that have been filed for CON in Tennessee. The Applicant was attempting to see if this rate would "work" for this project.

The Applicant then determined that an average \$9,191 would be deducted per patient, based on average deduction percentages anticipated by other providers. Deducting this amount from the estimated \$15,000 charge resulted in an average net charge of \$5,809 per patient. The Applicant then projected its average operating expenses per patient to be \$4,299. Subtracting the average expense (or, the anticipated "cost" per patient) from the anticipated net charge resulted in a projected profit of \$1,510. The anticipated profit amount appeared reasonable. Therefore, the Applicant decided that the \$15,000 average gross charge was a reasonable beginning point in the equation.

3. Section C, Orderly Development, Item 5

Please describe the two ASTC regulations that were waived during the Board for Licensing Health Care Facilities meeting on May 12, 2009 that the applicant will also request.

Response: The Applicant is not affiliated with the two MUA facilities (one in Knoxville and one in Nashville) that have already been approved and licensed. These two existing facilities did receive waivers from the Board for Licensing Health Care Facilities. As a matter of public record, the following is offered:

MUA is a manual method performed by licensed physicians. It is not an operative method. Licensure rules define a Surgical Procedure (#66) as being either a manual or an operative procedure. The Board of Licensing Health Care Facilities (the "Board") had never inspected an ambulatory surgical treatment center ("ASTC") that was limited to manual procedures, and several ASTC licensure requirements were viewed by both the MUA Medical Clinic of Knoxville, LLC and the MUA Medical Clinic of Nashville, LLC to be not applicable to an ASTC limited to manual procedures. Therefore, both clinics prepared waiver requests to be presented to the Board. To minimize the number of copies in this supplemental response, only those documents related to the Knoxville clinic are attached. However, the exact same sets of documents were submitted to and received by the Board by the Nashville clinic, also.

First, the clinic representatives reviewed licensure rules for ASTCs and prepared and submitted a list of items felt to be not applicable to manual surgical procedures (*Supplemental 2.3.1*).

Clinic representatives met with Ann Reed and Licensure's General Counsel on April 04, 2009 to go over the list of items. This list was pared down at the request of Ms. Reed, and then submitted to the Board (*Supplemental 2.3.2*). Further documentation from a nationally-known anesthesiologist was also submitted to the Board (*Supplemental 2.3.3*).

Clinic representatives attended the May 12, 2009 meeting of the Board, and 3 waiver requests were conditionally granted to the Clinics (*Supplemental 2.3.4*). Official notification from the Board of these three conditional waiver requests was provided to the Clinic's representative (*Supplemental 2.3.5*). Once the Clinic was built and inspected by Licensure, the results of the conditional waivers were submitted to the Board for its September 9, 2010 meeting (*Supplemental 2.3.6*).

The scheduled meeting of September 9, 2010 was delayed until November 10, 2010 due to mechanical problems at the scheduled meeting location.

Meeting on November 10, 2010, the Board granted the requested waivers, but the official letter from Licensure did not include all of the waivers granted (*Supplemental 2.3.7*). This particular letter specified that a separate room for clean and sterile supplies and provisions for collecting, storing, and disposal of biohazard waste was waived.

Later, the Board notified the Clinic in writing that waivers (1) regarding the anesthetic to be utilized, (2) permission to utilize a manually-operated anesthesia machine, and (2) permission to utilize a two-hour battery backup anesthesia machine were granted (*Supplemental 2.3.8*).

Since the Applicant will also be performing MUA, the Applicant anticipates requesting and being approved for the same Licensure waivers as have been granted for the two existing MUA ASTCs in Tennessee. The Applicant will rely on these prior waivers when applying to Licensure.

**COMMENTS REGARDING WAIVER REQUESTS TO
STANDARDS FOR
AMBULATORY SURGICAL TREATMENT CENTERS**

**February 14, 2013
12:55pm**

Submitted by: The MUA Medical Clinic of Knoxville, LLC ("Applicant")

The Applicant has no comments on the following sections:

1200-8-10-.02	Licensing Procedures
1200-8-10-.03	Disciplinary Procedures
1200-8-10-.09	Life Safety
1200-8-10-.12	Patient Rights
1200-8-10-.13	Policies & Procedures for Health Care Decision-Making
Appendix I	

The Applicant has comments on the following sections, as follows:

1200-8-10-.01 Definitions

(66) Surgical Procedure. A manual or operative method performed by a...

The Applicant respectfully reminds the reviewers that only MUA ("manipulation under anesthesia") services will be provided in the proposed Specialty ASTC. Therefore, only manual procedures, as opposed to the more normally-expected operative procedures, will occur in this facility.

1200-8-10-.04 Administration

(8) The ASTC shall perform only those surgical procedures...

The Applicant respectfully reminds the reviewers that only MUA ("manipulation under anesthesia") services will be provided in the proposed Specialty ASTC. Therefore, only manual procedures, as opposed to the more normally-expected operative procedures, will occur in this facility.

(9) ...medical director...or dentist...

The Applicant believes that the phrase "or dentist" is not applicable.

(16) The governing body...dental,...

The Applicant believes that the word "dental" is not applicable. **February 14, 2013**
12:55pm

(20)(b) Infection Control

- (2) Cats, dogs, or other animals shall not be allowed...except...

The Applicant will not have a pet therapy program.

- (3) Bed complete with mattress and pillow shall be provided. In addition, patient units shall be provided with a least 1 chair, a bedside table, an over bed tray and adequate storage space for toilet articles, clothing and personal belongings.

The Applicant will not have a patient room, as contemplated by this standard.

- (4) Individual wash cloths, towels and bed linens must be provided for each patient. Linen shall not be interchanged from patient to patient until it has been properly laundered.

The Applicant will not have a patient room, as contemplated by this standard. However, the procedure room will be a clean environment.

- (5) Bath basin water services, emesis basin, bedpan and urinal shall be individually provided.

The Applicant will not have a patient room, as contemplated by this standard. However, all of the above will be provided with the exception of bath basin water services.

- (6) Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans and similar items of equipment coming into intimate contact with patients shall be disinfected or sterilized after each use unless individual equipment for each is provided and then sterilized or disinfected between patients and as often as necessary to maintain them in a clean and sanitary condition. Single use, patient disposable items are acceptable but shall not be reused.

The Applicant will not have a patient room, as contemplated by this standard. However, glasses, thermometers, emesis basins, urinals, mouthwash cups and bedpans shall be single use, disposable items. Since there is no patient room, the other items will not be provided.

(20) (c)

- (3) ... Adoption of a standardized "central venous catheter insertion process" which shall contain these key components:

Not applicable (The provision of MUA services does not require central venous catheter insertion).

**February 14, 2013
12:55pm**

- (4) Written procedures concerning.... routine culturing of autoclaves and sterilizers

Not applicable (The provision of MUA services does not require a sterile environment).

- (6) Method of control used in relation to the sterilization of supplies and water, and a written policy addressing reprocessing of sterile supplies

Not applicable (The provision of MUA services does not require a sterile environment).

- (7) ... scrubbing practices, masking & dressing care techniques, disinfecting and sterilizing techniques...

Not applicable (The provision of MUA services does not require a sterile environment).

- (20) (e) Develop policies and procedures for testing a patient's blood for the presence of hepatitis B virus and the HIV (AIDS) virus in the event that an employee... health care provider rendering services at the facility is exposed to a patient's blood other body fluid, ...

The Applicant will not be providing laboratory services. In case of emergency, any patient or health care provider rendering services at the facility will be transferred to an area hospital.

- (20) (f) Annual influenza vaccination program...

The Applicant will not provide an annual influenza vaccination program, directly. However, the Applicant will make arrangements with area providers for its employees and associates.

- (21) Performance Improvement.

- (f) ... central venous catheter insertion process, and influenza vaccination program.

The provision of MUA services does not require central venous catheter insertion. The influenza vaccination program is addressed above.

1200-8-10-.05**Admissions, Discharges, and Transfers****February 14, 2013****12:55pm**

- (2) ... Does not preclude admission of patient to ASTC by dentist, podiatrist. concurrence with physician member of medical staff.
- (3) ...Qualified oral & maxilla-facial surgeons from admitting patients...
- (5) ... Dentist podiatrist ... electronic entry by signature.

The above three entries are not applicable. MUA services are not provided by dentists, podiatrists, or oral & maxilla-facial surgeons.

1200-8-10-.06**Basic Services**

- (1) Surgical services
 - (a) Facilities “restricted in services” they provide ... may be exempted from all or part of the requirements of this rule pertaining to lab, food & dietetic, and surgical.

This facility will restrict services, and requests exemption from all of the requirements of this rule pertaining to lab, food & dietetic, and operative surgical procedures.

- (c) “Hospital” may choose to separately license portion of facility as ASTC

Not applicable. The Applicant is not a hospital.

- (e) “Operating Rooms” must be supervised by experienced RN or MD of medicine or osteopathy.

Not applicable. The Applicant will have procedure rooms, only. However, the procedure room will be supervised by an experienced RN, MD, or DO.

- (f) LPN’s & surgical technologist (OR technicians) may serve as “scrub nurses” under care of RN

Not applicable. The Applicant will provide manual procedures only.

- (g) Qualified RN may perform circulating duties in “operating room”; LPN’s & technologists may assist...

Not applicable. However, the Applicant will provide an RN in the procedure room.

- (j) "Surgical technologists" must:
- (k) "Surgical technologists" must:
- (l) "Surgical technologists" must:

Items j, k, and l are not applicable. The provision of MUA services does not require a surgical technologist.

- (n) Organ donation forms must be in patient's chart

Not applicable. The provision of MUA services does not include the removal of organs.

- (o) Adequate equipment and supplies must be available to the operating room suites & post operative care area.

The Applicant will provide adequate equipment and supplies necessary for manual procedures in a clean procedure room, as opposed to equipment and supplies necessary for operative procedures in a sterile operating suite.

- (1) Call in system (OR)

Not applicable. The Applicant will provide adequate equipment and supplies necessary for manual procedures in a clean procedure room, as opposed to equipment and supplies necessary for operative procedures in a sterile operating suite.

- (q) at least 1 RN shall be in recovery area during patients recovery

As this standard anticipates the recovery of patients receiving operative surgical services, the Applicant requests permission to use either an RN or an LPN in the recovery area, only. An RN will be in the procedure room.

- (r) OR register must be complete and up-to-date

Not applicable, as there will be no operating room. The Applicant will provide a procedure room, and its register will be complete and up-to-date.

- (s) Operative report...

Not applicable, as there will be no operating room. The Applicant will provide a procedure room, and its register will be complete and up-to-date.

- (t) one or more "surgical suites"...

Not applicable, as there will be no operating room. The Applicant will provide a procedure room.

February 14, 2013

12:55pm

- (u) surgical suites are required to meet the same standards as hospital operating rooms, including those using general anesthesia

Not applicable, as there will be no operating room. The Applicant will provide a procedure room.

(2) Anesthesiology Services

- (c) Dentist, oral surgeon, podiatrist...

Not applicable. MUA services are not provided by dentists, podiatrists, or oral & maxilla-facial surgeons.

- (f) Equipment log (daily) of anesthesia equipment record of service and maintenance performed on all anesthesia machines, vaporizer and ventilators shall be in file.

Anesthesia equipment will be provided and a log will be maintained pursuant to this rule. However, vaporizers are not applicable, as there is no indication for use of a vaporizer because MUA procedures do not involve the use of an inhalation anesthetic.

(3) Medical Staff

Clarifying statement: The Medical Staff at an MUA will also include Doctors of Chiropractic.

- (4) Nursing Staff licensed RN on duty "at all times"

Clarifying statement: The Applicant will provide a licensed RN on duty at all times that procedures are being performed.

- (e) Standards on accordance with Nurse Practice Act of State of TN & Association of OR Nurses Standards of Practice.

Not applicable, as it relates to the Association of OR Nurses Standards of Practice, as MUA does not include operative procedures – only manual procedures.

- (5) Pharmaceutical services. ASTC "must provide" drugs & biological ... with accepted standards & such stored in a separate room or cabinet which shall be kept locked at all times.

Not applicable, as the provision of MUA procedures does not include the provision of drugs & biologicals. Any and all anesthesia drugs will be brought on site by the contracted anesthesiologist and not stored on site.

- (6) Ancillary services ... all ancillary or medical services including not limited to radiological, pharmaceutical or medical lab...

This facility will restrict services, and requests exemption from all of the requirements of this rule pertaining to laboratory and radiological services, as they will not be provided. Pharmaceutical services will be provided in a safe and effective manner.

- (7) Radiological Services

This facility will restrict services, and requests exemption from all of the requirements of this rule pertaining to radiological services, as they will not be provided.

- (8) Laboratory services

This facility will restrict services, and requests exemption from all of the requirements of this rule pertaining to laboratory services, as they will not be provided.

- (9) Food and Dietetic Services

This facility will restrict services, and requests exemption from all of the requirements of this rule pertaining to food and dietetic services, as they will not be provided. In addition, patients will not be in the MUA facility in excess of four (4) hours post-procedure.

1200-8-10-.10**Infectious & Hazardous Waste**

The Applicant respectfully states that this section (with the exception of paragraph No. 11) is not applicable, due to the definition of Hazardous Waste (Definitions, No. 29), the definition of Infectious Waste (Definitions, No. 38), and the fact that this Specialty ASTC will not be handling human anatomical remains. Wastes such as anesthesia needles and emesis will be disposed of in accordance to the Infection Control Policies set forth in Section 1200-8-10-.04(20).

1200-8-10-.11**Records & Reports**

- (2) facility report information contained medical records of patients "cancer or pre-cancerous or tumorous diseases" **February 14, 2013 12:55pm**

The Applicant respectfully states that this section is not applicable due to fact that this facility is neither diagnosing, treating nor reporting cancer. If cancer or tumorous growth is suspected in any patient, that patient will be referred to an appropriate cancer specialist.

1200-8-10-.14 Disaster Preparedness

- (3) The emergency power system shall:

The Applicant respectfully states that sub-sections (a), (b), and (c) are not applicable due to fact that the patients will not be incapable of self-preservation. Battery backups will be provided in accordance with sub-section (d).

- (4) ...automatic transfer switch ...

The Applicant respectfully states that all equipment requiring a power source will have a battery backup.

COMMENTS REGARDING WAIVER REQUESTS TO

February 14, 2013

12:55pm

**STANDARDS FOR
AMBULATORY SURGICAL TREATMENT CENTERS**

Submitted by: The MUA Medical Clinic of Knoxville, LLC ("Applicant")

The Applicant has no comments on the following sections:

1200-8-10-.02	Licensing Procedures
1200-8-10-.03	Disciplinary Procedures
1200-8-10-.09	Life Safety
1200-8-10-.12	Patient Rights
1200-8-10-.13	Policies & Procedures for Health Care Decision-Making
Appendix I	

The Applicant has comments on the following sections, as follows:

1200-8-10-.01 Definitions

(66) Surgical Procedure. A manual or operative method performed by a...

The Applicant respectfully reminds the reviewers that only MUA ("manipulation under anesthesia") services will be provided in the proposed Specialty ASTC. Therefore, only manual procedures, as opposed to the more normally-expected operative procedures, will occur in this facility.

1200-8-10-.04 Administration

(8) The ASTC shall perform only those surgical procedures...

The Applicant respectfully reminds the reviewers that only MUA ("manipulation under anesthesia") services will be provided in the proposed Specialty ASTC. Therefore, only manual procedures, as opposed to the more normally-expected operative procedures, will occur in this facility.

(9) ...medical director...or dentist...

The Applicant believes that the phrase "or dentist" is not applicable.

(16) The governing body...dental,...

1200-8-10-.06 Basic Services

(1) Surgical services

(1) Call in system (OR)

Not applicable. The Applicant will provide adequate equipment and supplies necessary for manual procedures in a clean procedure room, as opposed to equipment and supplies necessary for operative procedures in a sterile operating suite.

(q) at least 1 RN shall be in recovery area during patients recovery

As this standard anticipates the recovery of patients receiving operative surgical services, the Applicant requests permission to use either an RN or an LPN in the recovery area, only. An RN will be in the procedure room.

(2) Medical Staff

Clarifying statement: The Medical Staff at an MUA will also include Doctors of Chiropractic.

(3) Nursing Staff licensed RN on duty "at all times"

Clarifying statement: The Applicant will provide a licensed RN on duty at all times that procedures are being performed.

(e) Standards on accordance with Nurse Practice Act of State of TN & Association of OR Nurses Standards of Practice.

Not applicable, as it relates to the Association of OR Nurses Standards of Practice, as MUA does not include operative procedures – only manual procedures.

(4) Radiological Services

This facility will restrict services, and requests exemption from all of the requirements of this rule pertaining to radiological services, as they will not be provided.

1200-8-10-.10**Infectious & Hazardous Waste**

The Applicant respectfully states that this section (with the exception of paragraph No. 11) is not applicable, due to the definition of Hazardous Waste (Definitions, No. 29), the definition of Infectious Waste (Definitions, No. 38), and the fact that this Specialty ASTC will not be handling human anatomical remains. Wastes such as anesthesia needles and emesis will be disposed of in accordance to the Infection Control Policies set forth in Section 1200-8-10-.04(20).

1200-8-10-.14**Disaster Preparedness**

- (3) The emergency power system shall:

The Applicant respectfully states that sub-sections (a), (b), and (c) are not applicable due to fact that the patients will not be incapable of self-preservation. Battery backups will be provided in accordance with sub-section (d).

- (4) ...automatic transfer switch ...

The Applicant respectfully states that all equipment requiring a power source will have a battery backup.

February 14, 2013
12:55pm

INNOVATIVE PAIN SOLUTIONS, LLC

Carl R. Noback, M.D.
Medical Director

April 27, 2009

E. Graham Baker, Jr.
7000 Executive Center Drive, Suite 207
Brentwood, TN 37027

RE: Certificate of Need for MUA ASTC

Dear Mr. Baker:

I have been asked to review certain pertinent Tennessee rules and regulations and to make comments regarding the application of the aforementioned rules and regulations pertaining to a specialized ambulatory treatment center (ASTC) for the purpose of providing manipulation under anesthesia (MUA) services.

Items reviewed included:

RULES OF THE TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES
CHAPTER 1200-8-10
STANDARDS FOR AMBULATORY SURGICAL TREATMENT CENTERS.

The entire chapter was reviewed, with particular attention to:

1200-8-10-.14 (3) (d) Emergency generators are not required if the facility does not utilize anesthesia that renders the patient incapable of self preservation. However, the facility shall have an emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours.

These requirements, along with recommendations for clinical care from the American Society of Anesthesiologists, over 30 years of being a physician, and nearly 20 years of experience with the MUA procedure allow me to reach the



201 Montgomery Ave.
Sarasota, FL 34243
USA

PHONE (561) 400-9900
FAX (561) 208-8386
E-MAIL Dr.Noback@gmail.com

following conclusions:

For the performance of Manipulation Under Anesthesia (MUA) procedures, the patient receives a short-acting intravenous anesthetic to facilitate the performance of the procedure. Inhalation anesthetics, paralytic muscle relaxants, narcotics and long-lasting sedatives are not used during an appropriately performed MUA procedure and in fact will not be kept at the MUA ASTC facilities. Apart from a brief period of apnea, which is rare and lasts less than a minute for patients receiving an appropriate dose of the medication, patients receiving the intravenous anesthetic propofol in the limited dosages required to properly perform MUA are NOT "rendered incapable of self preservation" as defined in 1200-8-20-.14 (3) (d). The brief period of not breathing, for less time than a normal adult can hold his or her breath, if it occurs (and it does not in the majority of cases) is able to be supported by positive pressure ventilation utilizing either the anesthesia delivery system at the facility or an ambu bag with cylinder oxygen for the evanescent period during which apnea may occur. The standard initial (induction) dose of propofol for MUA is less than 1 mg/kg, less than half the standard induction dose for orthopedic surgery for example. If apnea occurs with such a low dose, as infrequently occurs, the expected duration is less than 30 seconds. The total dose of propofol for an MUA case is predictably less than 1.5 mg/kg, less again than the standard induction dose for open surgery. When propofol is used for both induction (2.0 to 2.5 mg/kg) and maintenance (0.1 to 0.2 mg/kg/min) of anesthesia, the majority of patients are generally awake, responsive to verbal command and oriented in approximately 7 to 8 minutes. Since the total dose of propofol for an MUA case will not predictably approach the 2.5 mg/kg range, the expectation, consistent with common experience, is that a patient is lucid and able to completely care for himself or herself in less than 7 minutes from the last administration of the drug. Even with an overdose of propofol, clarity of consciousness is expected within minutes. MUA protocols dictate the presence of a Board Certified Anesthesiologist, often in conjunction with a Certified Registered Nurse Anesthetist (CRNA), in order to protect the patient's safety and respond to the various clinical situations that may occur.

It is my opinion that, based on the analysis herein presented, emergency generators should not be required for an MUA ASTC in Tennessee due to the fact

that the anesthetic utilized does not render the patient incapable of self preservation absent egregious and unexpected malpractice.

Please feel free to contact me with any questions you may have.

Sincerely,

Carl R Noback MD

Carl R. Noback, M.D.
Medical Director
Innovative Pain Solutions, LLC

February 14, 2013
12:55pm



**TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES**
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
TELEPHONE (615) 741-7221
FAX 615-741-7051
www.tennessee.gov/health

July 8, 2009

E. Graham Baker, Jr.
Attorney-in-Law
7000 Executive Center Drive, Suite 207
Brentwood, TN 37027

RE: MUA Medical Clinic of Nashville, LLC, Nashville, TN
MUA Medical Clinic of Knoxville, LLC, Knoxville, TN

Dear Mr. Baker:

The waiver letter regarding the result of your waiver request from the Board for Licensing Health Care Facilities meeting on May 12, 2009 is attached. Please make note that this waiver request will only be granted based on the conditions set by the Board for the facilities in Nashville and Knoxville to submit the requested written statement of limitations for the following:

- (1) Anesthetic agents to be used;
- (2) A manual operated anesthesia machine to be used; and
- (3) A 2-hour battery operated back-up generator will be on hand.

Please submit the requested documentation to our office in order for this waiver to be considered effective for MUA Medical Clinic of Nashville and Knoxville. If you have any questions or concerns regarding this letter you may contact this office at (615) 741-7221.

Sincerely,

B. Ann Rutherford
B. Ann Rutherford, RN, BSN, MBA
Director of Licensure
Division of Health Care Facilities

AR/weh

cc: Gregory Sassman, Administrator, MUA Medical Clinic of Nashville, LLC
Steve Baker, Interim Director, Plans Review
West TN Regional Office



Supplemental 2.3.5
SUPPLEMENTAL- # 2

February 14, 2013
12:55pm

**TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES**
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
TELEPHONE (615) 741-7221
FAX 615-741-7051
www.tennessee.gov/health

July 8, 2009

E. Graham Baker, Jr.
Attorney-At-Law
7000 Executive Center Drive, Suite 207
Brentwood, TN 37027

RE: MUA Medical Clinic of Nashville, LLC, Nashville, TN
MUA Medical Clinic of Knoxville, LLC, Knoxville, TN

Dear Mr. Baker:

The Board for Licensing Health Care Facilities met on May 12, 2009. The following request was granted:

TO WAIVE REGULATIONS 1200-8-10.14(3) AND 1200-8-10-.14(4) REGARDING THE REQUIREMENTS FOR THE EMERGENCY POWER SYSTEM AND THE AUTOMATIC TRANSFER SWITCH. THIS WAIVER WILL BE CONSIDERED EFFECTIVE UPON THE RECEIPT OF A WRITTEN STATEMENT OF LIMITATIONS OF ANESTHETIC AGENTS TO BE USED, INDICATION A MANUAL OPERATED ANESTHESIA MACHINE TO BE USED, AND A 2-HOUR BATTERY OPERATED BACK-UP GENERATOR WILL BE ON HAND.

Board action was taken in accordance with Section 68-11-209, Chapter 11, Tennessee Code Annotated, which gives the Board authority to waive rules and regulations that do not have a detrimental effect on the health, safety and welfare of the public.

If you have any questions you may contact this office at (615) 741-7221.

Sincerely,

B. Ann Rutherford, RN, BSN, MBA
Director of Licensure
Division of Health Care Facilities

AR/weh

cc: Gregory Sassman, Administrator
MUA Medical Clinic of Nashville, LLC
Steve Baker, Interim Director, Plans Review
WTRO
File
Dee Ganaway

February 14, 2013
12:55pm

E. GRAHAM BAKER, JR.
ATTORNEY AT LAW

7000 EXECUTIVE CENTER DRIVE • SUITE 207
BRENTWOOD, TN 37027
TEL 615-370-3380
FAX 615-370-3393
graham@grahambaker.net

September 7, 2010

Ann Reed, RN, Director
Board for Licensing Health Care Facilities
Tennessee Department of Health
227 French Landing, Suite 501
Heritage Place, Metrocenter
Nashville, TN 37243

Re: MUA Medical Clinic of Knoxville, LLC
Waiver Requests; Your Note of September 3, 2010

Dear Mrs. Reed:

On behalf of MUA Medical Clinic of Knoxville, LLC and in response to your request, the following is offered regarding limitations granted by the Board in 2009:

1. anesthetic agents to be used; Local anesthetics may be used in the form of Lidocaine and/or Marcaine. Propofol, an anesthetic used to produce relaxation and light sleep, will be utilized before or during MUA procedures. Patients who have received Propofol can be easily aroused, are able to follow simple commands, and can be mobile and capable of self-preservation in 3-5 minutes. Propofol will be administered IV via Heparin lock.

2. indication a manual operated anesthesia machine to be used; A manually-operated anesthesia machine will be used in the form of an Ambubag with Oxygen for manual ventilation in the event of emergency. Mechanical ventilation is not required with this level of sedation.

and

3. a two hour battery operated back-up generator will be on hand. It is the understanding of the applicant that the Board waived the requirement of a backup generator on site. The manual anesthesia machine does not require a battery backup, nor does the crash cart. However, our EKG unit has a two hour battery backup, as will exit lights (already addressed in the plans, as all exit lights will have built-in battery backups).

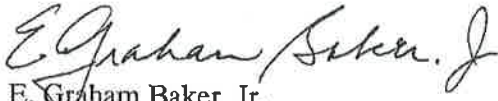
Representatives from the Clinic will be at the meeting on September 9, 2010 to address any questions of the Board and/or Staff.

Ann Reed, R.N., Director
September 7, 2010

February 14, 2013
12:55pm

Thank you for your attention to this matter. If you have any questions prior to the meeting, please contact me at your convenience.

Sincerely,



E. Graham Baker, Jr.
/np

c: Doug Lensgraf, D.C.
Gary O'Shaughnesy, D.O.
Steve Young
Wanda Hines, Licensure



Supplemental 2.3.7
SUPPLEMENTAL- # 2
RECEIVED NOV 14, 2013
12:55pm

**TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES**
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
TELEPHONE (615) 741-7221
FAX 615-741-7051
www.tennessee.gov/health

November 19, 2010

E. Graham Baker, Jr.
Attorney At Law
7000 Executive Center Drive, Suite 207
Brentwood, TN 37027

RE: Waiver Request: MUA Medical Clinic of Knoxville, LLC, Knoxville

Dear Mr. Baker:

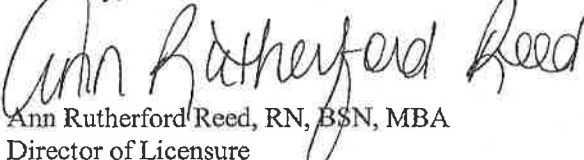
The Board for Licensing Health Care Facilities met on November 10, 2010. The following request was granted:

**TO ALLOW MUA MEDICAL CLINIC OF KNOXVILLE, LLC., KNOXVILLE TO
WAIVE THE 2006 AIA GUIDELINE 3.1-2.1.7.4 REGARDING A SEPARATE ROOM OR
CLOSET FOR STORING CLEAN AND STERILE SUPPLIES AND AIA GUIDELINE
3.1-2.1.7.5 REGARDING PROVISIONS BEING MADE FOR SEPARATE
COLLECTION, STORAGE, AND DISPOSAL OF SOILED MATERIALS (BIOHAZARD
WASTE).**

Board action was taken in accordance with Section 68-11-209, Chapter 11, Tennessee Code Annotated, which gives the Board authority to waive rules and regulations that do not have a detrimental effect on the health, safety and welfare of the public.

If you have any questions you may contact this office at (615) 741-7221.

Sincerely,


Ann Rutherford Reed, RN, BSN, MBA
Director of Licensure
Division of Health Care Facilities

ARR/weh

cc: ETRO
File
Dee Ganaway



Supplemental 2.3.8
SUPPLEMENTAL- # 2

February 14, 2013
12:55pm

2013 FEB 14 PM 12:53

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
TELEPHONE (615) 741-7221
FAX 615-741-7051
www.tennessee.gov/health

September 2, 2011

E. Graham Baker, Jr.
Attorney-At-Law
7000 Executive Center Drive, Suite 207
Brentwood, TN 37027

RE: MUA Medical Clinic of Nashville, LLC, Nashville, TN
MUA Medical Clinic of Knoxville, LLC, Knoxville, TN

(REVISED COPY)

Dear Mr. Baker:

This is a revised copy of the approval letter dated July 8, 2009 granting your requested waivers.

The Board for Licensing Health Care Facilities met on May 12, 2009. The following request was granted:

TO WAIVE REGULATIONS 1200-8-10.14(3) AND 1200-8-10.14(4) REGARDING THE REQUIREMENTS FOR THE EMERGENCY POWER SYSTEM AND THE AUTOMATIC TRANSFER SWITCH. THIS WAIVER WILL BE CONSIDERED EFFECTIVE UPON THE RECEIPT OF A WRITTEN STATEMENT OF LIMITATIONS OF ANESTHETIC AGENTS TO BE USED, INDICATION A MANUAL OPERATED ANESTHESIA MACHINE TO BE USED, AND A 2-HOUR BATTERY OPERATED BACK-UP POWER SOURCE WILL BE ON HAND.

Board action was taken in accordance with Section 68-11-209, Chapter 11, Tennessee Code Annotated, which gives the Board authority to waive rules and regulations that do not have a detrimental effect on the health, safety and welfare of the public.

If you have any questions you may contact this office at (615) 741-7221.

Sincerely,

Ann Rutherford Reed, RN, BSN, MBA
Director of Licensure
Division of Health Care Facilities

ARR/weh

cc: Gregory Sassman, Administrator, MUA Medical Clinic of Nashville, LLC
Bill Harmon, Director, Plans Review
WTRO
File
Dee Ganaway

COPY-

SUPPLEMENTAL-3

Spinal Healthcare Associates, PC
CN1212-060

SUPPLEMENTAL- # 3

February 15, 2013

3:30pm

WEEKS & ANDERSON

An Association of Attorneys

2021 RICHARD JONES ROAD, SUITE 350

NASHVILLE, TENNESSEE 37215-2874

TELEPHONE 615/383-3332

FACSIMILE 615/383-3480

KENT M. WEEKS
ROBERT A. ANDERSON

DIRECT TELEPHONE NUMBER: 615/370-3380

F. B. MURPHY, JR.
E. GRAHAM BAKER, JR.

February 15, 2013

Phillip M. Earhart
Health Services Development Examiner
Tennessee Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Supplemental Information: Certificate of Need Application CN1212-060
Spinal Healthcare Associates, PC

Dear Phillip:

Enclosed are three (3) copies of responses to your third supplemental questions regarding the referenced Certificate of Need application. If you have any additional questions, please contact me.

Sincerely,



E. Graham Baker, Jr.

/np/

Enclosures as noted

For purposes of this application responses should address the following definitions:

***MUA-** process where the patient is put under anesthesia by a nurse anesthetist or anesthesiologist and manipulation and stretching occur.*

***MUJA-** process where joint injections occur. The patient has not been put under anesthesia by a nurse anesthetist or anesthesiologist.*

Response: The Applicant agrees with the above broad definitions.

1. Section A, Item I2

On page 7 of the original application, the applicant discusses writing off Medicare/Medicaid care. The project estimates 15% Medicare, 80% TennCare, and 5% commercial with net revenue of \$196,205 in Year 1(130 patients) and \$426,000 (150 patients) in Year 2. Please breakout the contractual adjustments for \$987,500 in Year 1 of the Projected Data Chart from the gross charges.

Response: The amounts shown are estimated contractual adjustments. The Applicant is not currently contracted with these carriers as specialists; we are only currently contracted as general care providers. The carriers' fee schedules change according to the specific licensing (general or specialist) for your respective contracts with them.

We feel like we will be adjusting off around \$148,125.00 on Medicare patients as the trend of their contracted rates are set lower than any other carrier. This also includes the change in the reimbursement that is expected by the Health Care Reform Act. The TennCare adjustment is estimated to be \$790,000, which amount is estimated due to our current billings with TennCare and our existing patient population. Many facilities are no longer taking Medicare and TennCare patients, but since we continue to take these patients, our totals continue to rise. Also, there is an anticipated drop in reimbursement due to the Health Care Reform Act.

Further, the percentage of what we currently write off is approximately 50%, so we assume the TennCare write-off will approximate that percentage.

Lastly, commercial carriers will not give you fee schedules for MUA unless you are already contracted with them as MUA ASTC. Since we are not currently contracted, our anticipated fee schedule is only an estimate. All insurance carriers have different reimbursement levels for various procedures, and some of these rates depend on what the individual plan will allow. Some commercial insurance carriers reimburse at 110% of the Medicare fees, and some reimburse much lower. Therefore, our estimates are based on past experience on what we are currently billing for and writing off.

As an aside, we anticipated 170 patients in Year 2 – not 130 patients.

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2. 1st supplemental, page 4- Which MUA procedures will TennCare pay for?

Response: The following assumes the question involves the chart on page 10, question 4.

The MUJA CPT codes will not be utilized, as we will not perform MUJA. We contacted several TennCare carriers and asked if the MUA CPT codes were billable codes, and that information was given in the first set of supplemental questions that were submitted. The chart is repeated below for those MUA codes that we will perform:

CPT Code	Description	Covered by AmeriChoice? Y/N	Covered by BCBST? Y/N
22505	spine	Y	N
27275	hip	Y	Y
23700	Shoulder	Y	Y
27194	Pelvis	Y	Y
24300	Elbow	Y	Y
26340	Finger	Y	Y
27870	Ankle(open)	Y	Y
27860	Ankle	Y	Y
21073	TMJ	N	N
25259	Wrist	Y	Y

3. Section B. Project Description

On Page 10 of the original application, the applicant describes MUA as a process whereby patients are placed under anesthesia and then stretched and manipulated. MUJA is presented both as an adjunct therapy and as a screening tool. The last sentence on this page indicates "however if such injections completely alleviate pain such blocks may well preclude the need for additional MUA procedures." If the patient receives relief from the MUJA that is part of the screening process, are they still charged the \$15,000 global fee which results in \$1,510 profit per patient?

Response: The Applicant will not perform MUJA. All references to MUJA have been removed from the application, as have references to the C-Arm, which will not be purchased as a part of or is a part of this application. See Replacement pages 10, 15, and 28.

Regarding screening: if the patient is a chiropractic patient, Dr. Wooster will determine if the patient would fit the qualifications to consider Manipulation under Anesthesia. One of the criteria in determining if the patient might qualify for MUA is whether or not after conservative care for the last six to eight weeks the patient still has limited or no improvement in symptoms or findings. The patient may also be an appropriate candidate for MUA if he/she is still experience pain after undergoing various invasive treatments (such as surgery) or is not a candidate for surgery.

Not all patients will qualify for MUA treatment. The patient would have to be medically cleared by going through a range of testing. We would do Range of Motion and nerve conduction testing on the patient. The medical doctor or anesthesiologist will look at the patient's medical history, physical history, X-rays (MRI or CT if needed) and all related exams, testing and any relevant notes regarding the patient and make the determination if the patient has the ability to undergo anesthesia. MAC exams (chest x-rays) and EKG will be conducted if the patient is over a 50 or if physical condition warrants. These test will be conducted prior to interview with the anesthesiologist, so that the anesthesiologist can determine what medication would best suit the needs of the patient.

Social history will also be included in the determination process. This will be the work type and duties of the patient, smoking, drinking, sleep habits and if there is any recreational drug use.

Patients might be referred to our ASTC for MUA from other chiropractors, orthopedic doctors or other pain center physicians. If this is the case, all medical records would need to be requested and viewed, along with the patient being medically cleared by one of our doctors of medicine and seen by the anesthesiologist to determine if undergoing anesthesia would be an option for this patient. (same treatment as above).

Since MUJA is described as a screening tool, please estimate how many patients will receive only the joint injections vs. the MUA.

Response: The Applicant will not perform MUJA. All references to MUJA have been removed from the application, as have references to the C-Arm, which will not be purchased as a part of or is a part of this application. See Replacement pages 10, 15, and 28.

At what point does the MUJA procedure cease being part of MUA and become strictly a pain management injection?

Response: The Applicant will not perform MUJA. All references to MUJA have been removed from the application, as have references to the C-Arm, which will not be purchased as a part of or is a part of this application. See Replacement pages 10, 15, and 28.

Will every patient receive MUJA before MUA? If so, how many joint injections are anticipated per patient? Does this occur before the 3-day process for MUA? If so, how much time is the MUJA given to work before MUA is performed?

Response: The Applicant will not perform MUJA. All references to MUJA have been removed from the application, as have references to the C-Arm, which will not be purchased as a part of or is a part of this application. See Replacement pages 10, 15, and 28.

Since the PC that owns this entity already has contractual relationships with Humana, Windsor and United, please clarify why they would contract with this proposed entity at what appears to be a much higher charge than it currently receives (especially if the patient is only receiving MUJA)?

Response: The Applicant will not perform MUJA. All references to MUJA have been removed from the application, as have references to the C-Arm, which will not be purchased as a part of or is a part of this application. See Replacement pages 10, 15, and 28.

The PC is not an ASTC. Separate contracts have to be negotiated according to provider and provider type with various carriers. Further, we would not be able to change any contractual rate: the carriers tell us what the rate will be and we either accept it or do not have a contract.

Please clarify if the applicant is already using the CPT codes designated for manipulation for joint anesthesia at the existing adjoining pain clinic owned by the applicant. If so, are these procedures currently being reimbursed by TennCare? Is a setting such as an ASTC required to conduct MUJA procedures?

Response: No. MUJA codes require an anesthesiologist, and one is not currently on staff at the pain clinic. The Applicant will not perform MUJA. All references to MUJA have been removed from the application, as have references to the C-Arm, which will not be purchased as a part of or is a part of this application. See Replacement pages 10, 15, and 28.

The 2nd supplemental responses (pages 1-2-received 2/14/13) show a range of payments (TennCare, Medicare, Commercial and Other) for MUA and joint injections with a note indicating the TennCare reimbursements are an average of what could be ascertained by various TennCare MCOs. These payments are significantly lower than the \$15,000 per case listed in the original application {Gross Charge \$15,000 per case-\$9,191(deductions) = \$5,809 per patient; Applicant projected its operating costs to be \$4,299 per patient which results in \$1,510 profit per patient (5,809-4,299=\$1,510 profit per patient)} The application does not provide any details regarding how many of the MUA vs. MUJA procedures will be performed.

Response: The Applicant will not perform MUJA. All references to MUJA have been removed from the application, as have references to the C-Arm, which will not be purchased as a part of or is a part of this application. See Replacement pages 10, 15, and 28.

4. Economic Feasibility, Item 4, Projected Data Chart

The response from the applicant on how one fee will be charged to patients is noted. However, further clarification is needed. The applicant states the customary rate of \$15,000 in this application was calculated using MUA's approved by the HSDA in both the Nashville and Knoxville facilities. The previous MUA applications did not include contemplated joint injection procedures (MUJA). Please clarify how the \$15,000 customary charge was adopted from the previous two approved MUA ASTCs when they did not include MUJA procedures in their applications?

Response: The Applicant will not perform MUJA. All references to MUJA have been removed from the application, as have references to the C-Arm, which will not be purchased as a part of or is a part of this application. See Replacement pages 10, 15, and 28.

NOTE: *Section B is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. Section C addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.*

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response: Spinal Health Care Associates, P.C. ("Applicant"), 8132 Cordova Road, Suite 101, Cordova, TN 38106, owned by Rock Wooster, D.C., 8132 Cordova Road, Suite 102, Cordova, TN 38106, and managed by itself, files this application for a Certificate of Need for establishment of a specialty ambulatory surgical treatment center ("ASTC") providing only manipulation under anesthesia ("MUA") services. This new ASTC will be located in an existing office building, and will have one (1) procedure room, one (1) exam room, one (1) recovery room, along with other related space. The Applicant will provide only MUA and related services, which are manual surgical procedures, and no operative surgical procedures will be performed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately \$471,667, which includes the cost of the filing fee.

The Applicant is owned by Rock Wooster, D.C., and is self-managed. Articles of Organization and the organizational chart are attached as *Attachment A.4*. The only member of the Applicant is Dr. Wooster.

MUA is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the 1930s. Leading references put the use of MUA in the United States as far back as 1938, when Persols International Medical Clinic from Great Britain brought the procedures to the United States through Doctors Shiel, Clauborne, Mensor, and others, as reported in the Bibliography in the textbook, "Manipulation Under Anesthesia, Concepts In Theory and Application," Gordon, R., et.l., Taylor and Francis, April 2005. The process involves relaxing the patient (with anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

- A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of \$5 million) and other facility projects (construction cost in excess of \$2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

Response: The Applicant's Owner has a chiropractic practice at the same address, but adjacent to the space to be renovated for this project. Approximately 2,100 GSF will be renovated in Suite 101 at a total cost of \$110,000 (\$10,000 site preparation plus \$110,000 renovation costs). Please see *Attachment B.II.A.2* for a letter stating that this amount (\$110,000) is sufficient for renovation costs.

Finally, the total land and building have a combined fair market value (FMV) of \$1,720,000. The space for this ASTC will approximate 1/6th of the building. Therefore, the FMV of the real estate for this project is approximately \$286,667. As the rent (initial term of the lease is 3 years) will be \$4,000 per month, the FMV exceeds the actual lease costs (\$144,000). The FMV is listed on the Project Costs Chart.

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase.

1. Architectural and Engineering Fees	\$ 3,000 00
2. Legal, Administrative (Excluding CON Filing Fee), Consultant	70,000 00
3. Acquisition of Site	
4. Preparation of Site	10,000 00
5. Construction Costs (Possible Renovation)	100,000 00
6. Contingency Fund	
7. Fixed Equipment (Not included in Construction Contract)	
8. Moveable Equipment (List all equipment over \$50,000)	
9. Other (Specify)	
Subsection A Total	183,000 00

B. Acquisition by gift, donation, or lease.

1. Facility (Inclusive of Building and Land) (Estimated FMV)	286,667 00
2. Building Only	
3. Land Only	
4. Equipment (Specify)	
5. Other (Specify)	
Subsection B Total	286,667 00

C. Financing costs and fees

1. Interim Financing	
2. Underwriting Costs	
3. Reserve for One Year's Debt Service	
4. Other (Specify)	
Subsection C Total	0 00

D. Estimated Project Cost (A + B + C) \$ 469,667.00

E. CON Filing Fee \$ 3,000.00

F. Total Estimated Project Cost (D + E) TOTAL \$ 472,667.00

* estimated FMV will be paid by (lower) rental costs over time and are considered operational costs; therefore, the only "new" money required for the project is less than total listed above.



2012 DEC 7 PM 1 55

LETTER OF INTENT TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Commercial Appeal which is a newspaper of general
(Name of Newspaper)

circulation in Shelby and surrounding Counties, Tennessee on or before 12/10/2012 for one day.
(County) (Month / day) (Year)

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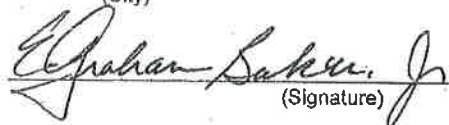
This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that Spinal Health Care Associates, P.C. ("Applicant"), 8132 Cordova Road, Suite 101, Cordova, TN 38106, owned by Rock Wooster, D.C., 8132 Cordova Road, Suite 102, Cordova, TN 38106, and managed by itself, intends to file an application for a Certificate of Need for establishment of a specialty ambulatory surgical treatment center ("ASTC") providing only manipulation under anesthesia ("MUA") services. This new ASTC will be located in an existing building, and will have one (1) procedure room, one (1) exam room, one (1) recovery room, along with other related space. The Applicant will provide only MUA and related services, which are manual surgical procedures, and no operative surgical procedures will be performed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that the specialty ASTC will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately \$474,667, which includes the cost of the filing fee.

The anticipated date of filing the application is: December 14, 2012.

The contact person for this project is E. Graham Baker, Jr. Attorney
(Contact Name) (Title)

who may be reached at: his office located at 2021 Richard Jones Road, Suite 350
(Company Name) (Address)

Nashville TN 37215 615 / 370-3380
(City) (State) (Zip Code) (Area Code / Phone Number)


(Signature)

12/07/ 2012
(Date)

graham@grahambaker.net
(E-mail Address)

=====

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

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The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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* The project description must address the following factors:

AFFIDAVIT

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STATE OF TENNESSEE
COUNTY OF DAVIDSON


NAME OF FACILITY: Spinal Healthcare Associates, PC (CN1212-060)

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.



Signature/Title Attorney at Law

Sworn to and subscribed before me, a Notary Public, this 15th day of February, 2013; witness my hand at office in the County of Davidson, State of Tennessee.



NOTARY PUBLIC

My Commission expires 11-4-2013



WEEKS & ANDERSON

An Association of Attorneys

2021 RICHARD JONES ROAD, SUITE 350

NASHVILLE, TENNESSEE 37215-2874

TELEPHONE 615/383-3332

FACSIMILE 615/383-3480

KENT M. WEEKS
ROBERT A. ANDERSON

F. B. MURPHY, JR.
E. GRAHAM BAKER, JR.

DIRECT TELEPHONE NUMBER: 615/370-3380

April 29, 2013

Melanie Hill, Executive Director
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

Re: Spinal Health Care Associates, P.C., CN1212-060

Dear Melanie:

I have requested a delay in the hearing on the two existing MUA ASTCs (Knoxville and Nashville) regarding the joint injection issue.

My client in this matter believes, as do I, that a hearing on Spinal Health Care Associates' CON application (now scheduled for May) is premature and should be delayed until after the joint injection issue is resolved.

Please consider this a request to delay the CON hearing on the reference application until after the MUA/MUJA joint injection issue is resolved.

Respectfully,


E. Graham Baker, Jr.
/np

c: Rock Wooster, D.C.



State of Tennessee

Health Services and Development Agency

Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2354/Fax: 615-741-9884

February 5, 2013

E. Graham Baker, PC
Weeks and Anderson
2012 Richard Jones Road, Suite 350
Nashville, TN 37215

Re: Certificate of Need Application – CN1212-060
Spinal Healthcare Associates, PC

Dear Mr. Baker:

The purpose of this letter is to remind you that your application remains incomplete. By law, if an application is not deemed complete within sixty (60) days after written notification is given to the applicant by agency staff, the application shall be deemed void. This application will be deemed void if it is not complete by February 15, 2013 at 4:30 pm.

The agency received your application on December 14, 2012. Supplemental information was first requested on December 18, 2012. It is imperative that you respond immediately to the December 18, 2012 request for supplemental information. This agency must have time to review your responses to ensure that you have responded fully to all requests for information.

I have enclosed a copy of our last request for supplemental information. Please respond no later than Wednesday, February 13, 2013 by 4:00 p.m.

Sincerely,

Melanie M. Hill
Executive Director

MMH/as

Enclosure

cc: Mark Farber



STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
741-2364

December 18, 2012

E. Graham Baker, P.C.
Weeks and Anderson
2012 Richard Jones Road, Suite 350
Nashville, TN 37215

RE: Certificate of Need Application CN1212-060
Spinal Healthcare Associates, PC

Dear Mr. Baker:

This will acknowledge our December 14, 2012 receipt of your application for a Certificate of Need for the establishment of a specialty ambulatory surgical center (ASTC) providing manipulation under anesthesia (MUA) services in an existing building located at 8132 Cordova Road, Suite 101, Cordova (Shelby County), TN 38106.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Wednesday December 26, 2012. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

1. Section A, Item 4

The Secretary of State corporate verification for Spinal Health Associates, P.C. is noted. However, please clarify the following;

- Please clarify the active assumed names of Shelby County Pain Clinic, Health Touch Body Works, and Cordova Pain Treatment Center listed under Spinal Health Care Associates, P.C. and their relationships.

Please explain the reason Spinal Health Care Associates, P.C is registered with the Tennessee Secretary of State as Suite 102, 8132 Cordova Road, while the applicant lists the location of the proposed facility as 8132 Cordova Road, Suite 101.

Who are the officers and/or members of Spinal Health Associates, P.C.?

Please clarify if Shelby County Pain Clinic, 8132 Cordova Road, Suite 102, Cordova, TN 38016 is associated with this project. If so, please verify this pain clinic is registered with the State of Tennessee. Also, please provide the name of the Medical Director and copy of license verification, any board orders, if applicable, from the following web-site: <http://health.state.tn.us/licensure/default.aspx>.

The NPPES (National Plan and Provider Enumeration System) lists Spinal Health Care Associates, P.C. NPI number as 1316137243 with an address of 8132 Cordova Road, Suite 102, Cordova, TN 38016. Please verify if either Shelby County Pain Clinic and Cordova Pain Treatment Center also files claims under this NPI number. If so, please explain why there is not a separate NPI number for each business. Also, will this proposed project also file claims under NPI 1316137243?

2. Section A, Item 6

The statement is made "the applicant will lease space from Rock A. Wooster and Jason Coleman, the landlord". Is this a sublease? Please clarify and resubmit a replacement page if necessary.

3. Section A, Item 12

Please clarify if the applicant Spinal Healthcare Associates, P.C or Rock Wooster, D.C. is currently a contracted provider for AmeriChoice, BlueCare or TennCare Select.

The applicant is projecting a TennCare payor mix of 80% (\$1,560,000) in Year One of the project. Please explain how this is possible while the applicant states "the applicant will take any TennCare patient out of network. If reimbursement is not available, the procedures will be written off as charity care".

Please refer to the BlueCross BlueShield of Tennessee Policy http://www.bcbst.com/mpmanual/Spinal_Manipulation_Under_Anesthesia.htm and respond to the following questions:

- According to the above BCBST policy what type of MUA procedures are considered investigational?
- When are MUA procedures medically appropriate?

Please attach a copy of the above mentioned BCBST MUA policy.

The applicant is projecting 15% Medicare patients for the proposed project. How is this possible while the applicant is stating the average age range for traditional MUA patients is 25-62?

Please review the Rules of the Bureau of TennCare (1200-13-16-.05 (1) (d)) at the following web-site, <http://tennessee.gov/sos/rules/1200/1200-13/1200-13-16.pdf> regarding medical necessity criteria. If MUA is considered investigational by Blue Cross Blue Shield of Tennessee how can TennCare revenue be projected at 80% of the proposed project?

The statement "MUA is considered a category 1 procedure by the AMA CPT coding system of reimbursable procedures. As a category 1 procedure it cannot be recognized by legal definition as an experimental or investigational procedure is noted". Please provide a reference from the AMA CPT billing guidelines to substantiate this statement.

The statement "we are aware of several insurance companies that reimburse for MUA care, but reimburse at discounted rates" is noted. Please provide the names of these mentioned companies and the amount of the discounted rates. Also, was this information factored into the projected data chart?

Please provide the coverage rationale (proven or unproven) according to United Healthcare, Manipulation Under Anesthesia: Medical Policy (Effective 5/1/12). Please respond to the above question by referencing the UnitedHealthcare Manipulation Under Anesthesia medical policy at the following web-site:

https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Manipulation_Under_Anesthesia.pdf

Please indicate if there have been any discussions by the applicant with any TennCare MCO's regarding contracting for this proposed project. If so, what is the stage of discussion?

The statement "we are not sure if reimbursement will be available for such patients until such time as we actually provide the procedures and submit the claims for payment" in regard to TennCare patients is noted. If MUA procedures have a gross charge of \$15,000 would it not be practical to determine if an insurance plan will reimburse an MUA claim prior to providing the service?

4. Section B, Project Description, Item I

The injecting of anti-inflammatory medication into painful joint using Manipulation Under Joint Anesthesia (MUJA) is noted. Please explain how these injections are used as a screening tool and describe the length of therapy. What are the CPT codes billed for MUJA procedures?

What is the expected percentage of total procedures that will be MUJA?

Does the applicant now receive reimbursement for MUJA procedures from TennCare?

Describe the MUA continuum of care.

How many MUA procedures has the applicant performed?

Are MUA procedures being performed now by the applicant in an office setting?

Please identify the physician, nurse and anesthesiologist who will be assisting with MUA in the proposed project.

The average charge of \$15,000 per patient is noted. What is the cost of the actual MUA procedure?

Please elaborate regarding the need for this project and why the applicant is seeking approval of the proposed service as an ASTC (Ambulatory Surgical Treatment Center)?

Please indicate if the proposed project will be providing manual procedures in a clean environment as opposed to traditional ASTC operative procedures in a sterile environment.

Please clarify if this proposed project is associated with existing MUA clinics in Nashville and Knoxville.

Please clarify if other chiropractors will have access to this ASTC to conduct MUA procedures.

5. Section B, Project Description, Item II A

The purchase of a C-Arm in the amount of \$40,000 is noted. Please indicate what type of equipment this is and its importance in conducting MUA procedures. Is there a separate patient charge for the use of this equipment?

6. Section B, Project Description Item III (Plot Plan) and Item IV (Simple Drawing)

The applicant notes \$100,000 for construction cost in the narrative but places "possible renovation" in parenthesis in the amount of \$100,000 in the Project Costs Chart. Please clarify.

The floor plan of the proposed site is noted. Please explain why the simple line drawing is titled "Cordova Pain Management, Ambulatory Surgery Center Floor plan".

7. Section C, Need, Item 1.a (Service Specific Criteria-ASTC)

Please clarify how the applicant can appropriately address any of the ASTC specific criteria while it is unknown if Medicare, TennCare and commercial insurance reimburse for MUA services.

8. Section C, Need, Item 1.a (Service Specific Criteria-ASTC (4)

Please indicate when the applicant projects to perform a minimum of 800 cases per room.

9. Section C, Need, Item 4.B.

Please indicate if there are any special needs of the service area population other than overmedicating patients with painkillers. How will the long-range plans of the facility take into consideration the special needs identified in the service area population?

10. Section C, Need Item 5

The applicant mentions Robert C. Gordon, D.C. has trained all the doctors in This proposed project. Please verify Robert C. Gordon is licensed in the State of Tennessee as a D.C.

11. Section C, Economic Feasibility, Project Costs Chart

There is a calculation error in the Project Costs Chart. Please correct and resubmit.

12. Economic Feasibility, Item 2, Project Funding

The letter from First Tennessee verifying \$200,000 to implement the proposed project is noted. However, the applicant plans to maintain an average monthly balance sufficient to serve as cash reserves. Since the 80% of the projected revenue is TennCare and there is a probability of a large number of charity care, please provide additional documentation of adequate cash reserves to cover the balance and any additional unforeseen projects costs.

The Spinal Healthcare Associates P.C. Balance Sheet indicates a loan to Shareholder in the amount of \$586,685.39. Since this is a large percentage of current assets, what is the purpose of this loan?

13. Economic Feasibility, Item 3

Please compare the renovated cost per GSF to other ASTC projects for Years 2009-2011 using the applicant's toolbox on HSDA's web-site located at http://tennessee.gov/hsda/applicants_tools/app_tool_box.shtml

14. Economic Feasibility, Item 4, Projected Data Chart

The applicant has stated in the application one fee will be charged to patients. Please explain how this fee is calculated.

A Medical Director is listed on the Projected Data Chart at a cost of \$210,000 per year. Please indicate the name of the Medical Director and his/her background.

There is an error in the amount in the Year 2 column under insurance. Please correct and resubmit a replacement page.

15. Section C., Economic Feasibility, Item 5

The statement clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy and anesthesiologists will bill for their own perspective services is noted. Please indicate the estimated amount these providers will charge outside the MUA procedure. Also, if the applicant accepts a charity case does that guarantee the above professionals will not bill?

16. Section C, Economic Feasibility, Item 6.B

Please indicate the top 10 projected CPT reimbursed procedures for this proposed project.

CPT Code	Brief Description	Amount

The applicant has provided some common CPT codes. Please complete the following table in regards to BlueCare and AmeriChoice:

CPT Code	Description	Covered by AmeriChoice? Y/N	Covered by BCBST?Y/N
22505			
27275			
23700			
27194			
24300			
26340			
27870			
27860			

17. Section C, Orderly Development, Item 1

Please indicate if there are any transfer agreements with any hospitals. If so, please list those hospitals.

Please indicate if practitioners who will provide care at the proposed MUA ASTC will have admitting privileges at area hospitals. If so, please list those hospitals.

18. Section C, Orderly Development, Item 4

Please provide a copy of the license of providers who have been identified to provide clinical services in this project.

19. Section C, Orderly Development, Item 5

The statement "certain waivers will be requested as no operative surgical procedures will take place" is noted. Is the applicant referring to two ASTC regulations that were waived during the Board for Licensing Health Care

Facilities meeting on May 12, 2009 for MUA Medical Clinics in Brentwood and Knoxville? If so, please explain.

20. Section C, Orderly Development, Item 8

The Tennessee Department of Licensure Practitioner Profile Data information indicates there was an above settlement reported on January 23, 2008 for Rock Wooster, DC. Please describe this above average settlement.

Also, there appears to be adverse license actions associated with Rock Wooster. Please provide a copy of the board order dated March 31, 2011 from the Department of Health Licensure web-site. The address of the web-site is http://health.tn.gov/DisciplinaryExclusion/boardorder/display/1108_830_033111

According to the Bank Records provided, it appears Chiropractic Physicians Jason Coleman and Jeffrey Becker are associated with the proposed project. Please provide web-based verification of their licenses and copies of any board orders by the Tennessee Board of Chiropractic Examiners.

21. Section C, Orderly Development, Item 12

The applicant mentions MUA facilities in Knoxville and Nashville. Please indicate if these facilities are contracted with TennCare MCOs and Medicare for MUA services.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Friday February 15, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

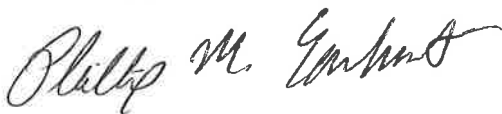
- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person

unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

A handwritten signature in cursive script, reading "Phillip M. Earhart".

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

PME
Enclosure